EATING DISORDERS: Inpatient Level of Care

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Patient Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Patient's Home Address:	Parent/Guardian Name *(if patient under 18)*:
Patient or Parent/Guardian Phone *(if patient under 18)*: **Primary Phone: ( ) Alternate Phone: ( )**	**Patient or Parent/Guardian Email *(if patient under 18)*:**

Section II: PROVIDER INFORMATION

Date Requested:	Facility Name:	Facility Address:

Facility NPI #:	Facility Tax ID #:	Facility Contact Person:	Phone:	Facsimile:	Email:
			( )	( )	

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*	Requested Admit Date:	Type of Commitment: *Please check.*
☐ Initial Admit ☐ Concurrent Review/Additional Days ☐ Retro Auth		☐ Involuntary ☐ Voluntary

Number of Initial Days Requested:	Number of Additional Days Requested:	Estimated Length of Stay:	Target Discharge Date:

Admission Source/Type: ***Please check or specify.***

☐ Direct Admit ☐ Step Up from Intensive Outpatient ☐ Transfer from Outside Hospital (*Name:* _____)
☐ Emergency Room ☐ Step Up from Outpatient Therapy
☐ Step Up from Day Treatment ☐ Other: _____

Primary Diagnosis/ICD-10 Code: ***Please check/specify.***

☐ Anorexia Nervosa/ICD-10: _____ ☐ Eating Disorder NOS/ICD-10: _____
☐ Bulimia Nervosa/ICD-10: _____ ☐ Other _____/ICD-10: _____

Secondary Diagnosis/ICD-10 Code(s):

Previous Eating Disorder Treatment: ***Please check/specify all that apply.***

☐ Day Treatment/Partial Hospitalization ☐ Intensive Outpatient Therapy ☐ Residential ☐ Other: _____
☐ ECT/Electroconvulsive Therapy ☐ Outpatient Therapy ☐ TMS/Transcranial Magnetic Stimulation _____
☐ Inpatient ☐ Pharmacologic Agents

Presenting/Current Eating Disorder Behaviors/Symptoms: ***Please check all that apply.***

☐ Anxiety	☐ Distorted body image	☐ Frequent body weight fluctuations	☐ Preoccupied with body weight
☐ Binge eating	☐ Diuretic use	☐ Going to bathroom after eating	☐ Purging
☐ Chewing and spitting	☐ Eating alone	☐ Hiding/hoarding food	☐ Refusing to eat
☐ Colon cleansing	☐ Enema use	☐ Laxative use	☐ Restricting food
☐ Depression	☐ Excessive exercise	☐ Makes excuses for not eating	☐ Self-induced vomiting
☐ Denial of hunger	☐ Fasting	☐ Obsession with food/nutrients	☐ Skipping meals
☐ Diet pills	☐ Feelings of shame/guilt when eating	☐ Preoccupied with body shape	☐ Strict habits/routines around food

Height:	Admit Weight:	Admit BMI:	Admit % of Ideal Body Weight (IBW):	Current Weight:	Current BMI:	Current % Ideal Body Weight (IBW):

(Please check service being requested.) QUESTION	YES	NO	COMMENTS/NOTES
A. ☐ Acute Psychiatric Inpatient Admission:			
1. Does the patient have a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified?	☐	☐	
2. Will the patient's disorder be expected to improve and/or deterioration cease if medically appropriate treatment according to current medical standards is provided?	☐	☐	
3. Did the patient present with symptoms of medical instability?	☐	☐	
3. a. If, *yes*, does the patient have any of the following symptoms? ***Please check/specify all that apply.*** ☐ Bradycardia (HR <40) ☐ Hypotension (< 90/60 mm Hg) ☐ Poorly controlled diabetes mellitus ☐ Cardiac dysfunction ☐ Kidney dysfunction ☐ Temperature < 97° F ☐ Dehydration ☐ Liver dysfunction ☐ Other: _____ ☐ Glucose < 90 mg/dl ☐ Orthostatic blood pressure changes ☐ Hypokalemia ☐ Other electrolyte imbalances	☐	☐	

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Name (Last, First MI):	DOB:	Age:	PEHP ID #:

(Please check service being requested.) **QUESTION (*cont'd*)**	YES	NO	COMMENTS/NOTES
4. Is the patient's weight 85% less than ideal body weight (IBW) and/or a Body Mass Index (BMI) of 16 or below?	☐	☐	
4. a. If, *no*, does the patient have evidence of any of the following? ***Please check all that apply.*** ☐ Weight loss of > 15% in one month. ☐ Rapidly approaching a weight at which medical instability occurred in the past. ☐ *Child/adolescent* has a body weight less < 85% of IBW during a period of rapid growth.	☐	☐	
5. For *Anorexia Nervosa* patient, does the patient require 24-hour medical/nursing intervention to provide immediate interruption of the food restriction, excessive exercise, purging and/or use of laxative/diet pills/diuretics to avoid imminent, serious harm due to medical consequences or to avoid imminent, serious complications to a co-morbid medical condition?	☐	☐	
6. For *Bulimic* patient, is 24-hour medical/nursing intervention required to provide immediate interruption of the binge/purge cycle to avoid imminent, serious harm due to medical consequences or to avoid imminent, serious complications to a co- morbid medical condition (e.g., pregnancy, uncontrolled diabetes)?	☐	☐	
B. ☐ **Acute Psychiatric Inpatient Continued Stay:** 1. Despite reasonable therapeutic efforts does the patient have any of the following clinical evidence? ***Please check.*** ☐ Persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs). ☐ Emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs). ☐ Progressive increases in hospital privileges have exacerbated the psychiatric symptoms thereby necessitating continued hospitalization. ☐ Patient has had a severe reaction to a medication that requires daily monitoring and/or adjustment by the attending psychiatrist.	☐	☐	
2. Does the current treatment plan include documentation of diagnosis (DSM- 5), individualized goals, treatment modalities needed and provided on a 24- hour basis, discharge planning, and intensive family and/or support system's involvement occurring at least once per week, unless clinically contraindicated?	☐	☐	
3. Is the current or revised treatment plan yielding significant, measurable improvement in the symptoms and/or issues meeting criterion?	☐	☐	
4. Does the patient's weight remain < 85% IBW or BMI ≤ 16?	☐	☐	
5. Did the patient fail to achieve a reasonable or expected weight gain despite provision of adequate caloric intake?	☐	☐	
6. For *children/adolescents and involuntarily hospitalized adults*, is there evidence of continued inability to adhere to a meal plan and maintain control over urges to binge/purge such that continued supervision during and after meals and/or in bathrooms is require?	☐	☐	
7. For *voluntary adult patients*, is there collaboration and progress in ability to adhere to a meal plan and maintain control over urges to binge/purge?	☐	☐	

Aftercare Planning Notes:

Additional Comments:

Please fax completed form, CRISIS EVALUATION, and medical records to 801-366-7449.