PRIOR AUTHORIZATION for TOTAL ANKLE ARTHROPLASTY / REPLACEMENT

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 Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

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

Section II: PROVIDER INFORMATION

Rendering Provider:			*Rendering* Provider Address:		
Provider NPI #:	**Provider TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

Facility/Hospital:			*Facility/Hospital* Address:		
Facility NPI #:	**Facility TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*	**Requested Date of Service:**	**Place of Service:** *Please check.*
☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	**From:** **To:**	☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**
Are services related to a motor vehicle accident? ☐ Yes ☐ No *Date of Accident:* _____	**Are services related to a work-related injury?** ☐ Yes ☐ No *Date of Work Injury:* _____

Service (s) Requested: ***Please list all requested services regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.***

Service: _____ CPT/HCPCS code: _____ ☐ Bilateral ☐ Left ☐ Right ☐ Initial ☐ Revision

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QUESTION	YES	NO	COMMENTS/NOTES
A. ☐ Revision Total Ankle Arthroplasty (TAA):			
1. Is revision TAA (Total Ankle Arthroplasty) being requested due to a failed total ankle prosthesis?	☐	☐	
B. ☐ Initial Total Ankle Arthroplasty (TAA) / Replacement:			
1. Will TAA being done to replace an arthritic or severely degenerated ankle?	☐	☐	
2. Is the patient skeletally mature?	☐	☐	
3. Does the patient have moderate or severe pain with loss of ankle mobility and function?	☐	☐	
4. Is imaging consistent with severe arthritis/degeneration of the ankle due to osteoarthritis (degenerative arthritis), post-traumatic arthritis, rheumatoid arthritis, or inflammatory arthritis?	☐	☐	*Please submit imaging reports.*
5. Has the patient failed at least 6 months of conservative management (including physical therapy, non-steroidal anti-inflammatory drugs, and orthoses as indicated)?	☐	☐	
6. Does the patient have any of the following conditions? ***Please check all that apply.*** a. ☐ Arthritis in adjacent joints of the involved extremity (i.e., subtalar, or midfoot) b. ☐ Arthrodesis of the contralateral ankle c. ☐ Severe arthritis of the contralateral ankle	☐	☐	
7. Which artificial ankle prostheses or implant will be used? ***Please check.*** a. ☐ Agility LP™ Total Ankle * b. ☐ Cadence Total Ankle System c. ☐ Eclipse ™ Total Ankle * d. ☐ Hintermann Series H2 Total Ankle System e. ☐ INBONE™ Total Ankle * f. ☐ Infinity Total Ankle System * g. ☐ Kinos Axiom Total Ankle System h. ☐ Salto Talaris® Total Ankle Prosthesis * i. ☐ Salto XT j. ☐ STAR System * k. ☐ Topez Total Ankle Replacement l. ☐ Vantage® Total Ankle System m. ☐ Zimmer Trabecular Metal Total Ankle * o. ☐ Other (please specify): _____ **** PEHP approved product.***	☐	☐	***Product selection is <u>mandatory.</u>***

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QUESTION (*cont'd*)	YES	NO	COMMENTS/NOTES
8. Does the patient have any of the following conditions that are contraindicated for TAA? *Please check all that apply.* a. ☐ Absence of the medial or lateral malleolus b. ☐ Active or prior deep infection in the ankle joint or adjacent bones c. ☐ Charcot Joint d. ☐ Corticosteroid injection into the joint within 12 weeks of the planned arthroplasty e. ☐ Extensive avascular necrosis of the talar dome f. ☐ Hindfoot or forefoot malalignment precluding plantigrade foot g. ☐ Insufficient bone or musculature such that proper component positioning or alignment is not possible h. ☐ Insufficient ligament support that cannot be repaired with soft tissue stabilization i. ☐ Lower extremity vascular insufficiency j. ☐ Neuromuscular disease resulting in lack of normal muscle function about the affected ankle k. ☐ Osteonecrosis l. ☐ Peripheral neuropathy (may lead to Charcot joint of the affected ankle) m. ☐ Poor skin and soft tissue quality about the surgical site n. ☐ Prior arthrodesis (fusion) at the ankle joint o. ☐ Prior surgery or injury that has adversely affected the affected ankle bone quality p. ☐ Psychiatric problems that hinder adequate cooperation during peri-operative period q. ☐ Severe anatomic deformity in adjacent ankle structures, including hindfoot, forefoot and knee joint r. ☐ Severe ankle deformity (e.g., severe varus or valgus deformity) that would not normally be eligible for ankle arthroplasty s. ☐ Severe osteoporosis, osteopenia or other conditions resulting in poor bone quality as this may result in inadequate bony fixation t. ☐ Significant malalignment of the knee joint u. ☐ Skeletal maturity not yet reached v. ☐ Vascular insufficiency in the affected limb	☐	☐	
9. Will intra-operative fresh frozen section analysis be done to determine the presence of infection during total ankle arthroplasty?	☐	☐	
10. Will total ankle arthroplasty be combined with a total talar prosthesis?	☐	☐	
11. Will patient-specific instrumentation for total ankle arthroplasty be used?	☐	☐	
12. Will a trans-fibular surgical approach be done for total ankle arthroplasty?	☐	☐	

Additional Comments:

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