PRIOR AUTHORIZATION for SPINAL CORD STIMULATOR (SCS) / DORSAL ROOT GANGLION (DRG) STIMULATOR

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.*
☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent

Requested Date of Service:
From: **To:**

Place of Service: *Please check.*
☐ 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 Injury: _____

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

Service Description: _____ CPT/HCPCS: _____ ☐ Bilateral ☐ Left ☐ Right

Service Description: _____ CPT/HCPCS: _____ ☐ Bilateral ☐ Left ☐ Right

Service Description: _____ CPT/HCPCS: _____ ☐ Bilateral ☐ Left ☐ Right

Service Description: _____ CPT/HCPCS: _____ ☐ Bilateral ☐ Left ☐ Right

A. Spinal Cord Stimulator (SCS) / Dorsal Root Ganglion (DRG) Stimulator Service Being Requested: *Please check.*
1. ☐ Pulse Generator/Receiver Replacement 2. ☐ Permanent Implantation 3. ☐ Removal 4. ☐ Replacement/Warranty Expired 5. ☐ Revision 6. ☐ Trial

B. Type of Stimulator Being Requested: *Please check.*
1. ☐ Cervical SCS 2. ☐ Dorsal Root Ganglion (DRG) Stimulator 3. ☐ Lumbar SCS 4. ☐ Thoracic SCS 5. ☐ Other (*please specify*): _____

(Please check service being requested.) **QUESTION**	**YES**	**NO**	**COMMENTS/NOTES**
C. ☐ Trial & Permanent Implantation of a Spinal Cord Stimulator (SCS) / Dorsal Root Ganglion (DRG) Stimulator:			
1. Does the patient have chronic intractable neuropathic pain?	☐	☐	
2. Is stimulator being requested for complex regional pain syndrome (CRPS) Type I or Type II?	☐	☐	
3. Is stimulator being requested for Failed Neck (cervical) Surgery Syndrome (FNSS) with significant upper extremity radicular pain?	☐	☐	
3.a. Did the patient undergo a cervical spine MRI that demonstrated that the patient has adequate epidural space for implantation	☐	☐	*Please submit copy of report.*
3.b. If the patient is approved for implantation of a cervical stimulator will intra-operative monitoring be provided?	☐	☐	
3.c. If the patient is approved for implantation of a cervical stimulator will percutaneous leads be placed as opposed to paddle leads?	☐	☐	
4. Is stimulator being requested for Failed Back (Lumbar) Surgery Syndrome (FBSS) with significant lower extremity radicular pain?	☐	☐	
5. Is stimulator being requested as a last resort treatment of severe painful diabetic neuropathy?	☐	☐	
5.a. Has nondiabetic etiologies been excluded as the cause of the severe painful neuropathy?	☐	☐	
5.b. Does the patient have stabilized glycemic control? *Please provide most recent Hemoglobin A1C result.*	☐	☐	

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

(Please check service being requested.) QUESTION (*cont'd*)	YES	NO	COMMENTS/NOTES
5.c. Has the patient failed any of the following drug classes? *Please check all that apply.* 1) ☐ Anticonvulsants (e.g., gabapentin, typical dose 1.8 g/day) 2) ☐ Opioid or Opioid-Like Drugs (e.g., tramadol or controlled release oxycodone) 3) ☐ Tricyclic Drugs (e.g., amitriptyline 25 to 150 mg before bed)	☐	☐	
6. Has conventional medical treatment (e.g., pharmacological, physical, psychological, surgery) failed to adequately control the chronic neuropathic pain?	☐	☐	
7. Has all other available treatment options been exhausted?	☐	☐	
8. Has evaluation been performed, and a stimulator has been recommended and will be performed by a board-certified physician in at least one of the following specialties? *Please check all that apply.* ☐ Anesthesiology ☐ Pain Management ☐ Neurology ☐ Physical Medicine and Rehabilitation ☐ Neurosurgery ☐ Spine Surgery	☐	☐	
9. Was it determined that the pain is not psychological in origin through a psychological evaluation?	☐	☐	*Please submit copy of psychological evaluation.*
10. Has it been determined that the patient is an appropriate candidate for implantation of a stimulator through psychological evaluation?	☐	☐	*Please submit copy of psychological evaluation.*
11. Is there evidence of an existing untreated substance abuse?	☐	☐	
12. Are there any contraindications to implantation of a stimulator (e.g., body size that is insufficient to support the weight and bulk of the device, coagulopathy, localized or disseminated infection, other implanted programmable devices [cardiac pacemaker, defibrillator], sepsis)?	☐	☐	
13. Is stimulator being requested for any of the following conditions? *Please check all that apply.* a. ☐ Cancer Pain b. ☐ Central Deafferentation Pain *(due to CNS damage from a stroke or complete spinal cord injury)* c. ☐ Cervical Trauma d. ☐ Cervical Disc Herniation e. ☐ Cervicogenic Headache f. ☐ Chronic Low Back Pain g. ☐ Critical Limb Ischemia (*as a technique to forestall amputation*) h. ☐ Drug-Refractory Chronic Cluster Headaches i. ☐ Glioma j. ☐ Intractable Angina k. ☐ Migraine Headaches l. ☐ Nociceptive Pain (*resulting from irritation, not nerve damage*) m. ☐ Occipital Nerve Pain n. ☐ Peripheral Vascular Disease (PVD) o. ☐ Postherpetic Neuralgia p. ☐ Radiation-Induced Brain Injury q. ☐ Stroke r. ☐ Visceral Pain	☐	☐	
D. ☐ Permanent Implantation of Spinal Cord Stimulator (SCS) / Dorsal Root Ganglion (DRG) Stimulator: ***Completion of Section C. also required for permanent.***			
1. Did the patient's symptoms improve by at least 50% during a trail of temporary electrodes for a minimum of 72-hours? ***Documented response to the trial is required.***	☐	☐	*Completion of Section C. also required.*
E. ☐ Replacement of Spinal Cord Stimulator (SCS) / Dorsal Root Ganglion (DRG) Stimulator: ***Completion of Section C. also required for replacement.***			
1. Can the existing stimulator and/or battery (generator) be replaced under warranty?	☐	☐	*Completion of Section C. also required.*
F. ☐ Revision or Removal of Spinal Cord Stimulator (SCS) / Dorsal Root Ganglion (DRG) Stimulator:			
1. Is revision or removal of the stimulator indicated for any of the following reasons? *Please check all that apply.* a. ☐ Development of Neurological Deficits b. ☐ Infection c. ☐ Intolerance by Patient d. ☐ Loss of Effectiveness e. ☐ Migration of Lead(s) f. ☐ Need for AICD (Automatic Implantable Cardioverter Defibrillator) g. ☐ Need for MRI (Magnetic Resonance Imaging) h. ☐ Painful Generator Site	☐	☐	

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

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