PRIOR AUTHORIZATION for CAPSULE ENDOSCOPY

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

Ordering/Rendering Provider:	*Ordering/Rendering* Provider Address:

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

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*	Requested Date of Service:	Requested CPT/HCPCS Code(s):
☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth ☐ Urgent	From: To:	

Primary Diagnosis/ICD-10 Code (s):	Secondary Diagnosis/ICD-10 Code (s):

QUESTION	YES	NO	COMMENTS/NOTES
1. Is capsule endoscopy (CE) being requested for any of the following indications? ***Please check all that apply.*** ☐ Colorectal cancer screening ☐ Detecting colorectal polyps, gastric varices, or hookworms ☐ Evaluating colon, esophagus, stomach ☐ Evaluating for intussusception ☐ Evaluating mucosal inflammation in ulcerative colitis ☐ Initial testing for diagnosis of gastro-intestinal bleeding ☐ Investigating duodenal lymphocytosis, small bowel neoplasm, suspected irritable bowel syndrome ☐ Portal hypertensive gastropathy staging ☐ To confirm pathology identified by other diagnostic means ☐ To diagnose intestinal graft vs. host disease ☐ To diagnose Takayasu's arteritis ☐ To plan radiation therapy ☐ To verify effectiveness of surgery	☐	☐	
2. Does the patient have any of the following contraindications to CE? ***Please check all that apply.*** ☐ Confirmed or suspected gastrointestinal obstruction, stricture, or fistula ☐ Dysphagia (difficulty swallowing) or other swallowing disorders ☐ Presence of cardiac pacemakers, cardiac defibrillators, or other implanted electro-medical devices	☐	☐	
3. Is CE being requested for evaluation of locoregional carcinoid tumors in the small bowel for a patient who has an established diagnosis of carcinoid syndrome?	☐	☐	
4. Is CE being requested to assist in the initial diagnosis of Celiac disease because the patient has a positive celiac specific serology (e.g., tissue transglutaminase IgA [tTG-IgA] antibody test), but is unable to undergo esophagogastroduodenoscopy [EGD) with biopsy (e.g., medically unstable, presence of known or suspected perforated viscus)?	☐	☐	***Please submit copy of all test results.***
5. Does the patient have an established diagnosis of Celiac disease and CE is being requested because the patient remains symptomatic (e.g., abdominal pain, bloating, chronic diarrhea, constipation, nausea and vomiting) despite adherence to prescribed therapy (i.e., strict gluten-free diet)?	☐	☐	
6. Is CE being requested for initial diagnosis of Crohn's disease because the patient has symptoms suspicious of Crohn's disease (i.e., abdominal cramping, abdominal pain, diarrhea, anemia, loss of appetite, weight loss)?	☐	☐	
6.a. If, Yes, does the patient have one (1) or more signs of inflammation (i.e., blood in the stool, elevated erythrocyte sedimentation rate [ESR], elevated C reactive protein [CRP], elevated white blood cell count [WBC], and fever)?	☐	☐	***Please submit copy of all test results.***
6.b. If, Yes, was there no evidence of the disease found on conventional, or standard, diagnostic tests (i.e., abdominal computed tomography [CT], CT enterography, magnetic resonance [MR] enterography, small-bowel follow-through [SBFT], and upper and lower endoscopy (esophagogastroduodenoscopy [EGD] and colonoscopy)?	☐	☐	***Please submit copy of all test results.***
7. Does the patient have an established diagnosis of Crohn's disease and CE is being requested for re-assessment because the patient remains symptomatic despite prescribed therapy (i.e., anti-inflammatory drugs [e.g. prednisone, mesalamine], immunomodulators [e.g., azathioprine, methotrexate], biologics [e.g., adalimumab, infliximab])?	☐	☐	
8. Is CE being requested to investigate suspicion of small intestinal bleeding?	☐	☐	
8.a. If, Yes, does the patient have objective evidence of recurrent, obscure gastrointestinal bleeding, including laboratory proven persistent or recurrent iron-deficiency anemia, laboratory proven persistent or recurrent positive fecal occult blood test, or visible bleeding?	☐	☐	***Please submit copy of all tests and results.***
8.b. If, Yes, was an upper and lower gastrointestinal endoscopy (EGD and colonoscopy) done within the last 12 months and did they fail to identify a bleeding source or were inconclusive?	☐	☐	***Please submit copy of procedures/results.***
9. Is CE being requested for surveillance of small intestinal tumors because the patient has Lynch Syndrome, Peutz-Jeghers Syndrome, or another polyposis syndrome that affects the small bowel?	☐	☐	

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.