PRIOR AUTHORIZATION for UVULOPALATOPHARYNGOPLASTY (UPPP)

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:**

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

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*	**Requested Date(s) 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 (s):	**Secondary Diagnosis/ICD-10 Code (s):**

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

Service Description: _____ CPT/HCPCS: _____

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QUESTION	YES	NO	COMMENTS/NOTES
1. Has the patient had either a facility/sleep lab based or home-based sleep study (polysomnography)*? **** Please submit copy of the sleep study (polysomnography) report.***	☐	☐	
2. Was the facility/sleep lab based or home-based sleep study (polysomnography/PSG) positive with diagnosis of obstructive sleep apnea (OSA) confirmed?	☐	☐	
2. a. If, Yes, was the apnea-hypopnea index (AHI), respiratory disturbance index (RDI), or respiratory event index (REI) greater than or equal to 15 events/hour with a minimum of 30 events?	☐	☐	
2. b. If, Yes, was the AHI, RDI, or REI greater than or equal to 5 and less than 15 events per hour with a minimum of 10 events **AND** at least one of the following? ***Please check all that apply.*** ☐ Documented history of stroke (Cerebrovascular Accident/CVA) or other brain injury ☐ Documented hypertension (systolic blood pressure > 140 and/or diastolic blood pressure > 90) ☐ Documented ischemic heart disease ☐ Documented symptoms of impaired cognition, mood disorders, or insomnia ☐ Excessive daytime sleepiness (documented Epworth Sleepiness Score greater than 10) ☐ Greater than 20 episodes of oxygen desaturation (less than 85%) during a full night sleep study ☐ One episode of oxygen desaturation less than 70%	☐	☐	
3. Was the patient prescribed* AutoPAP (Auto-Titrating Positive Airway Pressure) or CPAP (Continuous Positive Airway Pressure)? **** Medical records must document that the patient has attempted AutoPAP or CPAP before considering surgery.***	☐	☐	
4. Did the patient have an inadequate treatment response* to a trial of AutoPAP or CPAP? **** An inadequate treatment response means that despite compliance with using Auto-PAP or CPAP the patient's symptoms, such as excessive daytime sleepiness, and the number of apneas/hypopneas persist or increase.***	☐	☐	
5. Was the patient intolerant* of AutoPAP or CPAP despite adjustments to pressure and mask, as appropriate? **** Intolerance may include claustrophobia, difficulty tolerating pressure, inability to sleep with CPAP device, intolerance of nasal or mouth interface, nasal irritation, or repeated removal of CPAP unintentionally during sleep.***	☐	☐	

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.