PEHP Health & Benefits

PRIOR AUTHORIZATION for AIRWAY CLEARANCE DEVICES

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

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

Section II: PROVIDER INFORMATION

Date Requested:		Service Provider Name:
Service Provider NPI #:	Service Provider Tax ID #:	Service Provider Address:

Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Authorization Extension ☐ Pre-Authorization ☐ Retrospective Authorization ☐ Urgent	**Requested Authorization Period:**
Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**

Durable Medical Equipment (DME) Requested:

DME Description: _____ HCPCS code: _____ ☐ Purchase ☐ Rental ☐ Replacement

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QUESTION	YES	NO	COMMENTS/NOTES
A. ☐ **<u>For Airway Oscillating Devices and Mechanical Percussors:</u>** 1. Does the patient have cystic fibrosis/CF, chronic bronchitis, bronchiectasis, immotile cilia syndrome, or asthma?	☐	☐	
B. ☐ **<u>For Positive Expiratory Pressure/PEP Masks:</u>** 1. Does the patient have CF, chronic bronchitis, immotile cilia syndrome, asthma, or chronic obstructive pulmonary disease/COPD?	☐	☐	
C. ☐ **<u>For High-Frequency Chest Compression Systems</u>:** 1. Has the patient failed standard treatments to adequately mobilize retained secretions?	☐	☐	
2. Does the patient have bronchiectasis confirmed by CT scan characterized by daily productive cough for at least 6 months or by frequent (more than 2 times per year) exacerbations requiring antibiotic therapy?	☐	☐	
3. Does the patient have cystic fibrosis or immotile cilia syndrome?	☐	☐	
4. Is the patient within the first 6 months post-operatively following lung transplant and unable to tolerate standard chest physiotherapy?	☐	☐	
5. Does the patient have one of the following neuromuscular diseases? *Please check.* ☐ Acid maltase deficiency ☐ Anterior horn cell disease, including amyotrophic lateral sclerosis ☐ Hereditary muscular dystrophy ☐ Multiple sclerosis ☐ Myotonic disorder ☐ Paralysis of the diaphragm ☐ Post-polio ☐ Quadriplegia ☐ Other myopathies (*please specify*) _____	☐	☐	
D. ☐ **<u>For Mechanical In-Exsufflation Devices:</u>** 1. Does the patient have a neuromuscular disease that is causing a significant impairment of chest wall and/or diaphragmatic movement and for whom standard treatments have not been successful in adequately mobilizing retained secretions?	☐	☐	

Additional Comments:

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