PRIOR AUTHORIZATION for BREAST RECONSTRUCTION

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

Requested Date of Service:

Place of Service: *Please check.*
☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Facility Name:	Facility NPI #:	Facility Tax ID #:
Facility Address:	Facility Phone: ( )	Facility Facsimile: ( )
Primary Diagnosis/ICD-10 Code:	Secondary Diagnosis/ICD-10 Code:	

A. Date/Side of Mastectomy or Lumpectomy: *Please check.*
☐ Bilateral ☐ Left ☐ Right
Date (s): ____________________

B. Indication for Mastectomy or Lumpectomy: *Please check all that apply.*
☐ Breast Cancer (☐ *Bilateral* ☐ *Left* ☐ *Right*) ☐ Prophylactic (☐ *Bilateral* ☐ *Left* ☐ *Right*)
☐ Other____________________

C. Which breast will be reconstructed? *Please check.*
☐ Bilateral ☐ Left ☐ Right

D. Indication (s) for breast reconstruction: *Please check all that apply.*
☐ Implant Failure ☐ Symmetry ☐ Unsatisfactory Breast Reconstruction
☐ Other____________________

E. Which breast reconstruction procedure is being requested? *Please check all that apply.*
☐ Areolar & Nipple Reconstruction or Tattooing ☐ Augmentation Mammoplasty ☐ Autologous Fat Graft/Transplant via Liposuction
☐ Breast Implant Removal ☐ Breast Implant Removal & Subsequent Reimplantation ☐ Breast Reduction by Mammoplasty or Mastopexy
☐ Capsulectomy ☐ Capsulotomy ☐ Implantation of Breast Prosthesis ☐ Implantation of Tissue Expander
☐ Oncoplastic Reconstruction ☐ Tissue/Muscle Reconstruction (e.g., DIEP flap, SIEP flap, TRAM flap)
☐ Reconstructive Surgical Revision ☐ Other *(please specify)*: ____________________

F. For breast implant removal/implant removal with subsequent reimplantation, what was the initial indication for implant? *Please check all that apply.* ☐ **N/A**
1. ☐ Cosmetic/Augmentation 2. ☐ Breast Cancer (☐ *Bilateral* ☐ *Left* ☐ *Right*) 3. ☐ Other____________________

G. Will the patient be having any of the following breast reconstruction procedures (*please check all that apply*)? ☐ **Yes** ☐ **No**
☐ Autologous Fat Transplant using Adipose-Derived Stem Cells ☐ Body Lift Perforator Flap ☐ Vascularized Lymph Node Transfer ☐ Xenograft Cartilage Grafting

H. Autologous Fat Grafting/Autologous Fat Transfer (*use of adipose-derived stem cells is not covered*)? ☐ **N/A**
Technique: ☐ Lipectomy ☐ Liposuction Donor/Harvest Site: ______________ Graft Site: ______________ ☐ Bilateral ☐ Left ☐ Right
Technique: ☐ Lipectomy ☐ Liposuction Donor/Harvest Site: ______________ Graft Site: ______________ ☐ Bilateral ☐ Left ☐ Right

I. Will any of the following products be used with the reconstruction procedure (*please check all that apply*)? ☐ **Yes** ☐ **No** ☐ **N/A**
1. ☐ AlloDerm® 2. ☐ AlloMax™ 3. ☐ Biodesign® Nipple Reconstruction Cylinder 4. ☐ DermaCell™ 5. ☐ DermaMatrix Acellular Dermis
6. ☐ FlexHD Acellular Dermis 7. ☐ hMatrix® 8. ☐ NeoForm™ Dermis 9. ☐ Permacol® 10. ☐ Radiesse® 11. ☐ Repriza®
12. ☐ Strattice™ Reconstructive Tissue Matrix 13. ☐ SurgiMend® 14. ☐ Other (*please specify*): ____________________

J. Service (s) Requested: *Please list all requested services/CPT-HCPCS codes regardless of pre-auth requirement.*
Procedure/Service: ______________ CPT/HCPCS code: ______________ ☐ Bilateral ☐ Left ☐ Right
Procedure/Service: ______________ CPT/HCPCS code: ______________ ☐ Bilateral ☐ Left ☐ Right
Procedure/Service: ______________ CPT/HCPCS code: ______________ ☐ Bilateral ☐ Left ☐ Right
Procedure/Service: ______________ CPT/HCPCS code: ______________ ☐ Bilateral ☐ Left ☐ Right

Additional Comments:

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