



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 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 #:
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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

<b>Nature of Request:</b> <i>Please check.</i> <input type="checkbox"/> Auth Extension <input type="checkbox"/> Pre-Auth <input type="checkbox"/> Retro Auth <input type="checkbox"/> Urgent	<b>Requested Date of Service:</b>	<b>CPT Code:</b>
<b>Primary Diagnosis/ICD-10 Code:</b>	<b>Secondary Diagnosis/ICD-10 Code:</b>	

QUESTION	YES	NO	COMMENTS/NOTES
1. Is the test indicated for evaluation of locoregional carcinoid tumors of the small bowel in person with carcinoid syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the test indicated for evaluation of person with celiac disease with positive serology and negative biopsy?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Submit all lab results.</i>
3. Is the test indicated for re-evaluation of person with celiac disease who remain symptomatic despite treatment & there is no suspected or confirmed gastrointestinal obstruction, stricture, or fistulae?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the test indication for re-evaluation of persons with Crohn's disease who remain symptomatic despite treatment and there is no suspected or confirmed gastro-intestinal obstruction, stricture, or fistulae?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Is the test indicated for surveillance of small intestinal tumors in persons with Lynch syndrome, Peutz-Jeghers syndrome or other polyposis syndromes affecting the small bowel?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Is the test indicated for screening or surveillance of esophageal varices in cirrhotic persons with significantly compromised liver function (i.e., Child-Pugh score of Class B or greater) or other situations where a standard upper endoscopy with sedation or anesthesia is contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Is the test indicated for initial diagnosis of person with suspected Crohn's disease?	<input type="checkbox"/>	<input type="checkbox"/>	
7. a. Does the patient have abdominal pain or diarrhea plus 1 or more signs of inflammation (fever, elevated white blood cell count, elevated erythrocyte sedimentation rate, or bleeding)?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Submit all lab results.</i>
7. b. Was there no evidence of disease on conventional diagnostic tests, including small-bowel follow-through or abdominal CT scan/CT enterography, upper and lower endoscopy (esophago-gastro-duodenoscopy/EGD and colonoscopy)?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Submit all procedure &amp; imaging reports.</i>
8. Is the test indicated to investigate suspected small intestinal bleeding in persons with objective evidence of recurrent, obscure gastrointestinal bleeding (e.g., persistent, or recurrent iron-deficiency anemia and/or persistent or recurrent positive fecal occult blood test, or visible bleeding)?	<input type="checkbox"/>	<input type="checkbox"/>	
8. a. Did an upper and lower gastrointestinal endoscopies (EGD and colonoscopy) within the past 12 months fail to identify a bleeding source?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Submit EGD &amp; colonoscopy reports.</i>
9. Does the patient have known or suspected gastrointestinal obstruction, strictures, or fistulae?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Is the test being used for any of the following reasons? <i>Please check all that apply.</i> <input type="checkbox"/> Colorectal cancer screening <input type="checkbox"/> Detecting gastric varices <input type="checkbox"/> Evaluating for intussusception <input type="checkbox"/> Evaluating the colon <input type="checkbox"/> Evaluating the stomach <input type="checkbox"/> Evaluating for diseases involving the esophagus other than esophageal varices <input type="checkbox"/> Follow-up of persons with known small bowel disease other than Crohn's disease <input type="checkbox"/> Initial test in diagnosing gastrointestinal bleeding <input type="checkbox"/> Investigating duodenal lymphocytosis <input type="checkbox"/> Investigating small bowel neoplasm <input type="checkbox"/> Investigating suspected irritable bowel syndrome <input type="checkbox"/> Repeat to verify effectiveness of surgery <input type="checkbox"/> Screening test other than for esophageal varices <input type="checkbox"/> To confirm pathology identified by other diagnostic means <input type="checkbox"/> To stage portal hypertensive gastropathy	<input type="checkbox"/>	<input type="checkbox"/>	

**Additional Comments:**

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