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 #:

Section II: PROVIDER INFORMATION

Date Requested:		Rendering Service Provider Name:	
Rendering Service Provider NPI #:	Rendering Service Provider Tax ID #:	Rendering Service Provider Address:	
Rendering Service Provider Contact Person:		Rendering Service Provider Phone: ( )	Rendering Service Provider Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	Requested Date of Service:	CPT Code:
Primary Diagnosis/ICD-10 Code:	Secondary Diagnosis/ICD-10 Code:	

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?	☐	☐	
2. 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?	☐	☐	
3. Is the test indicated for initial diagnosis of person with suspected Crohn's disease?	☐	☐	
3. 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)?	☐	☐	*Submit all lab results.*
3. 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)?	☐	☐	*Submit all procedure & imaging reports.*
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?	☐	☐	
5. 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)?	☐	☐	*Submit all lab results.*
5. a. Did an upper and lower gastrointestinal endoscopies (EGD and colonoscopy) within the past 12 months fail to identify a bleeding source?	☐	☐	*Submit EGD & colonoscopy reports.*
6. 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?	☐	☐	
7. 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?	☐	☐	
8. Does the patient have known or suspected gastrointestinal obstruction, strictures, or fistulae?	☐	☐	
9. Does the patient have a cardiac pacemaker or other implanted electro-medical device?	☐	☐	
10. Does the patient have dysphagia or other swallowing disorder?	☐	☐	
11. Is the test being used for any of the following reasons? *Please check all that apply.* ☐ Colorectal cancer screening ☐ Detecting gastric varices or hookworms ☐ Evaluating for intussusception ☐ Evaluating the colon and/or stomach ☐ Evaluating for diseases involving the esophagus other than esophageal varices ☐ Evaluating mucosal inflammation in ulcerative colitis ☐ Follow-up of persons with known small bowel disease other than Crohn's disease ☐ Initial test in diagnosing gastrointestinal bleeding ☐ Investigating duodenal lymphocytosis, small bowel neoplasm, or suspected irritable bowel syndrome ☐ Repeat use to verify effectiveness of surgery ☐ Screening test other than for esophageal varices ☐ To confirm pathology identified by other diagnostic means ☐ To diagnose Takayasu's arteritis ☐ To plan radiation therapy ☐ To stage portal hypertensive gastropathy	☐	☐	

Additional Comments:

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