PRIOR AUTHORIZATION for INTERVERTEBRAL DISC PROSTHESES

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 ☐ Outpatient

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

Service (s) Requested: *Please list all requested services/CPT codes regardless of pre-authorization requirement.*

Procedure/Service: _____ CPT/HCPCS code: _____
Procedure/Service: _____ CPT/HCPCS code: _____
Procedure/Service: _____ CPT/HCPCS code: _____
Procedure/Service: _____ CPT/HCPCS code: _____

QUESTION	YES	NO	COMMENTS/NOTES
Cervical Disc Replacement:			
1. Is the patient skeletally mature?	☐	☐	
2. Does the patient have symptoms (e.g., radicular neck and/or arm pain and/or functional/neurological deficit) of cervical degenerative disc disease or herniated disc at one level from C3-C7?	☐	☐	
3. Do radiographic studies (e.g., CT scan, MRI, x-rays) confirm cervical degenerative disc disease or herniated disc at one level from C3-C7?	☐	☐	*Please submit imaging report(s).*
4. Has the patient failed at last 6 weeks of conservative management?	☐	☐	
5. Is prosthesis being requested because the patient has symptomatic degenerative disk disease or signs and symptoms of a herniated disc *beyond* the proposed surgical site?	☐	☐	
6. Is request for a subsequent (after) placement of a second artificial cervical disc at a level contiguous (next to) to a previously placed artificial disc?	☐	☐	
7. Is request for concurrent or planned sequential artificial disc replacement with cervical spinal fusion?	☐	☐	
8. Has the patient had a prior disc replacement and a new artificial disc would result in more than 2 contiguous disc replacement levels from C3 to C7?	☐	☐	
9. Is cervical artificial total disc replacement being used to treat symptomatic contiguous two level degenerative disc disease? *Please check product selection below.*	☐	☐	
10. Will one of the following cervical artificial disc products be used? *Product selection is mandatory.* a. ☐ BRYAN™ Cervical Disc b. ☐ Mobi-C® Cervical Disc Prosthesis c. ☐ PCM® Cervical Disc System d. ☐ PRESTIGE® Cervical Disc System e. ☐ PRESTIGE® LP Cervical Disc f. ☐ ProDisc-C™ Total Disc Replacement g. ☐ SECURE-C® Artificial Cervical Disc	☐	☐	

Additional Comments:

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