PEHP Health & Benefits

PRIOR AUTHORIZATION for MINIMALLY INVASIVE FUSION OF THE SACROILIAC JOINT (iFuse)

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:**	

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

Procedure/Service: _____ CPT/HCPCS code: _____ ☐ Left ☐ Right ☐ Bilateral

Procedure/Service: _____ CPT/HCPCS code: _____ ☐ Left ☐ Right ☐ Bilateral

Procedure/Service: _____ CPT/HCPCS code: _____ ☐ Left ☐ Right ☐ Bilateral

Procedure/Service: _____ CPT/HCPCS code: _____ ☐ Left ☐ Right ☐ Bilateral

QUESTION	YES	NO	COMMENTS/NOTES
1. Does the patient have SIJ (Sacroiliac Joint) syndrome or SIJ mediated mechanical low back pain?	☐	☐	
2. Has the back pain been present for more than 6 months?	☐	☐	
3. Does the patient have persistent moderate to severe SIJ pain (> 5 on 10-point VAS/Visual Analog Scale) despite conservative therapy?	☐	☐	
4. Was SIJ pain confirmed with at least 3 physical examination maneuvers (e.g., distraction test, compression test, thigh thrust, FABER [Patrick's] test, Gaenslen's maneuver, sacral sulcus tenderness) that stress the SIJ??	☐	☐	
5. Did the patient have a 75% or greater acute decrease in pain following a **required** fluoroscopically guided diagnostic intra-articular SIJ block using a local anesthetic confirming SIJ as a pain generator?	☐	☐	*Please submit procedure report & post-procedure pain diary.*
6. Has the patient failed to adequately respond to at least 6 months of non-surgical treatment? If "yes", did the patient try any of the following treatment? *Please check all that apply.* ☐ Activity Modification ☐ Course of Physical Therapy ☐ Opioids (if not contraindicated) ☐ Non-Steroidal Anti-Inflammatory Drugs/NSAIDs ☐ SIJ Steroid Injection	☐	☐	
7. Have other possible diagnoses been excluded through thorough clinical and radiological evaluation (e.g., L5/S1 compression, hip osteoarthritis)? *Please submit imaging reports.*	☐	☐	
8. Will the iFuse Implant System® ("iFuse") product be used for the SIJ fusion?	☐	☐	
9. Does the patient have any of the following conditions in *addition* to SIJ pain? *Please check all that apply.* ☐ Acute, traumatic instability of the SIJ ☐ Generalized Pain Behavior (e.g., Somatoform Disorder) ☐ Generalized Pain Disorder (e.g., Fibromyalgia) ☐ Infection, tumor, or fracture ☐ Systemic Arthropathy (e.g., ankylosing spondylitis or rheumatoid arthritis)	☐	☐	
10. Does the patient in addition to SIJ pain have neural compression as seen on an MRI or CT that correlates with the patient's symptoms or other more likely source for their pain? *Please submit imaging reports.*	☐	☐	

Additional Comments:

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