



PRIOR AUTHORIZATION for MINIMALLY INVASIVE FUSION OF THE SACROILIAC JOINT

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

Nature of Request: <i>Please check.</i> <input type="checkbox"/> Auth Extension <input type="checkbox"/> Pre-Auth <input type="checkbox"/> Retro Auth <input type="checkbox"/> Urgent	Requested Date of Service:	Place of Service: <i>Please check.</i> <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Inpatient <input type="checkbox"/> Office <input type="checkbox"/> Outpatient
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Facility Name:	Facility NPI #:	Facility Tax ID #:
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Facility Address:	Facility Phone: ()	Facility Facsimile: ()
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Primary Diagnosis/ICD-10 Code:	Secondary Diagnosis/ICD-10 Code:
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Service (s) Requested: *Please list all requested services/CPT codes regardless of pre-authorization requirement.*

Procedure/Service: _____ CPT/HCPCS code: _____ Left Right Bilateral
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QUESTION	YES	NO	COMMENTS/NOTES
1. Does the patient have SIJ (Sacroiliac Joint) syndrome or SIJ mediated mechanical low back pain?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the back pain been present for more than 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the patient have persistent moderate to severe SIJ pain (> 5 on 10-point VAS/Visual Analog Scale) despite conservative therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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 stressed the SIJ and caused the patient's typical pain?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please submit procedure report & post-procedure pain diary.</i>
6. Have other possible diagnoses been excluded through thorough clinical and radiological evaluation (e.g., L5/S1 compression, hip osteoarthritis)?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please submit imaging reports.</i>
7. Has the patient failed to adequately respond to at least 6 months of non-surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Did failed "non-surgical" treatment include all the following treatments? <input type="checkbox"/> Activity Modification <input type="checkbox"/> Course of Physical Therapy <input type="checkbox"/> Opioids (Unless contraindicated) <input type="checkbox"/> Non-Steroidal Anti-Inflammatory Drugs/NSAIDs <input type="checkbox"/> SIJ Steroid Injection	<input type="checkbox"/>	<input type="checkbox"/>	
9. Will any of the following products/implants be used for the SIJ fusion? Product selection is mandatory. a. <input type="checkbox"/> iFuse Implant System® b. <input type="checkbox"/> SI-FIX c. <input type="checkbox"/> SImmetry® d. <input type="checkbox"/> Sillex™ e. <input type="checkbox"/> SI-LOK™ f. <input type="checkbox"/> Other (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	
10. Does the patient have any of the following conditions in addition to SIJ pain? Please check all that apply. <input type="checkbox"/> Acute, traumatic instability of the SIJ <input type="checkbox"/> Generalized Pain Behavior (e.g., Somatoform Disorder) <input type="checkbox"/> Generalized Pain Disorder (e.g., Fibromyalgia) <input type="checkbox"/> Infection, tumor, or fracture <input type="checkbox"/> Systemic Arthropathy (e.g., ankylosing spondylitis or rheumatoid arthritis)	<input type="checkbox"/>	<input type="checkbox"/>	
11. 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 the source for their pain?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please submit imaging reports.</i>

Additional Comments:

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