PRIOR AUTHORIZATION for PANNICULECTOMY

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: _____

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Procedure/Service: _____ CPT/HCPCS code: _____

QUESTION	YES	NO	COMMENTS/NOTES
1. Does the patient have a Grade 1 – 5 panniculus according to the American Society of Plastic Surgeons (ASPS) grading system? *Please check.* ☐ **Grade 1:** Panniculus covers hairline and mons pubis, but not the genitals. ☐ **Grade 2:** Panniculus covers genitals and upper thigh crease. ☐ **Grade 3**: Panniculus covers upper thigh. ☐ **Grade 4:** Panniculus covers mid-thigh. ☐ **Grade 5:** Panniculus covers knees and below.	☐	☐	*Please submit (frontal & lateral) photos of patient standing erect.*
2. Has there been a significant amount of weight loss (approximately 14 BMI points or achieving a BMI ≤ 30)? **Weight Lost** _____ **Current Weight** _____ **Current Height** _____ **Current BMI** _____	☐	☐	
2. a. Was weight loss accomplished with bariatric surgery? **Date of Surgery:** _____ **Type of Bariatric Surgery:** *Please check all that apply.* ☐ Adjustable Gastric Banding ☐ Duodenal Switch with Biliopancreatic Diversion ☐ Roux-en-Y Gastric Bypass ☐ Sleeve Gastrectomy ☐ Other (*please specify*): _____	☐	☐	*If NO, please skip 2.b – 2.c.*
2. b. Did the patient participate in the PEHP Bariatric Pilot Program? **Eligible Employer Groups: State & Salt Lake City.*	☐	☐	
2. c. Has it been at least 18 months since the patient had bariatric surgery?	☐	☐	
2. d. Whether the weight loss was accomplished surgically or non-surgically, has the patient's weight remained stable for the most recent 6 months?	☐	☐	
3. Does the abdominal pannus cause medical complications related to the excess tissue and skin folds (such as candidiasis, intertrigo, or tissue necrosis)?	☐	☐	*If NO, please skip 3. a.*
3. a. Has at least a 3-month trial of conservative management (such as oral and/or topical medication, dressing changes) failed as evidenced by photo and documentation in medical records?	☐	☐	*Please submit photos of medical complications.*

Additional Comments:

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