PRIOR AUTHORIZATION for SPINAL CORD STIMULATOR (SCS)

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:		Ordering Physician:
Physician Provider NPI #:	Physician Tax ID #:	Physician Address:

Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*
☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth ☐ Urgent

Place of Service: *Please check.*
☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Requested Date of Service:

Spinal Cord Stimulator Service Requested: *Please check.*
☐ Pulse Generator/Receiver Replacement ☐ Permanent ☐ Removal ☐ Revision ☐ Trial

Facility Name:	**Facility NPI #:**	**Facility Tax ID #:**

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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	QUESTION	YES	NO	COMMENTS/NOTES
1.	Is the prescribing physician board certified in pain management and anesthesiology?	☐	☐	*Please submit copy of certifications.*
2.	Has conventional medical treatment (pharmacological, surgical, physical, and/or psychological) failed?	☐	☐	
3.	Has the patient exhausted all other available treatment options?	☐	☐	
4.	Is there evidence of existing untreated drug addiction?	☐	☐	
5.	Was it determined that the pain is not psychological in origin through a psychological evaluation?	☐	☐	
6.	Do any contraindications to implantation exist (i.e. sepsis or coagulopathy issues)?	☐	☐	
7.	Were the symptoms improved by at least 50% with a minimum 72-hour clinical trial of temporary electrodes?	☐	☐	*Answer required if seeking permanent placement of SCS.*
8.	Is SCS being indicated for any of the following conditions? *Please check.* ☐ Complex regional pain syndrome type I or II ☐ Failed lumbar back surgery syndrome ☐ Severe diabetic neuropathy with stable glycemic control	☐	☐	
9.	If SCS is for severe diabetic neuropathy has the patient failed the following? *Please check.* ☐ Anticonvulsants ☐ Opioid/Opioid-like drugs ☐ Tricyclic drugs	☐	☐	
10.	Is SCS being indicated for any of the following conditions? *Please check.* ☐ Cancer pain ☐ Cervical trauma ☐ Cervical disc herniation ☐ Chronic low back pain ☐ Critical limb ischemia as a technique to forestall amputation ☐ Intractable angina ☐ Central deafferentation pain r/t CNS damage from a stroke or complete spinal cord injury ☐ Drug-refractory chronic cluster headaches ☐ Failed cervical spine surgery syndrome ☐ Nociceptive pain resulting from irritation, not nerve damage ☐ Visceral pain ☐ Occipital nerve stimulation ☐ Peripheral vascular disease ☐ Postherpatic neuralgia	☐	☐	
11.	Is revision or removal of SCS indicated for any of the following reasons? *Please check.* ☐ Development of neurological deficits ☐ Infection ☐ Intolerance by patient ☐ Loss of effectiveness ☐ Migration of lead (s) ☐ Need for MRI study ☐ Need for AICD (Automatic Implantable Cardioverter Defibrillator) ☐ Painful generator site	☐	☐	

Additional Comments:

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