PEHP Health & Benefits

PRIOR AUTHORIZATION for TOTAL ANKLE ARTHROPLASTY

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-auth requirement.*

Procedure/Service: _____ CPT/HCPCS code: _____

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QUESTION	YES	NO	COMMENTS/NOTES
1. Does the patient have osteoarthritis, post-traumatic arthritis, or rheumatoid arthritis in the affected ankle?	☐	☐	
2. Has the patient failed at least 6 months of conservative management, including physical therapy, non-steroidal anti-inflammatory drugs, and orthoses as indicated?	☐	☐	
3. Which FDA approved artificial ankle prosthesis or implant will be used? *Product selection is mandatory.* ☐ Agility LP™ Total Ankle ☐ Eclipse ™ Total Ankle ☐ INBONE™ Total Ankle ☐ STAR (Scandinavian Total Ankle Replacement) System ☐ Salto Talaris® Ankle Prosthesis ☐ Other (please specify): _____	☐	☐	
4. Does the patient have any of the following conditions? *Please check all that apply.* ☐ Active or prior deep infection in the ankle joint or adjacent bone ☐ Avascular necrosis of the talus ☐ Charcot Joint ☐ Hindfoot or forefoot mal-alignment precluding plantigrade foot ☐ Insufficient ligament support that cannot be repaired with soft tissue stabilization ☐ Lower extremity vascular insufficiency ☐ Neuromuscular disease resulting in lack of normal muscle function about the affected ankle ☐ Peripheral neuropathy ☐ Poor skin and soft tissue quality about the surgical site ☐ Prior arthrodesis (fusion) at the ankle joint ☐ Skeletal maturity not yet reached ☐ Prior surgery or injury that has adversely affected the affected ankle bone quality ☐ Psychiatric problems that hinder adequate cooperation during peri-operative period ☐ Severe ankle deformity that would not normally be eligible for ankle arthroplasty ☐ Severe osteoporosis, osteopenia or other conditions resulting in poor bone quality ☐ Significant mal-alignment of the knee joint ☐ Weight greater than 250 lbs	☐	☐	
5. Will the total ankle arthroplasty/replacement procedure be customized to the individual using any of the following? *Please check all that apply.* ☐ Customized, individual-specific ankle implant ☐ Customized templates, and/or instrumentation ☐ Gender specific implant	☐	☐	
6. Is revision being requested due to a failed total ankle prosthesis?	☐	☐	

Additional Comments:

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