PEHP Health & Benefits

PRIOR AUTHORIZATION for TOTAL ANKLE ARTHROPLASTY / REPLACEMENT

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 ☐ Date of Service Change ☐ Place of Service Change ☐ Pre-Auth ☐ Code Change(s) ☐ Provider Change ☐ Retro Auth ☐ Urgent

Requested Date of Service:

Place of Service: *Please check.*

☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient ☐ Other ____________________________

Facility Name:	**Facility NPI #:**	**Facility Tax ID #:**
Facility Address:	**Facility Phone:** ( )	**Facility Facsimile:** ( )

Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**
Are services related to a motor vehicle accident? ☐ Yes ☐ No *Date of Accident:* ____________________________	**Are services related to a work-related injury?** ☐ Yes ☐ No *Date of Injury:* ____________________________

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

Procedure/Service: ______________________ CPT/HCPCS code: ______________ ☐ Bilateral ☐ Left ☐ Right ☐ Initial ☐ Revision

Procedure/Service: ______________________ CPT/HCPCS code: ______________ ☐ Bilateral ☐ Left ☐ Right ☐ Initial ☐ Revision

Procedure/Service: ______________________ CPT/HCPCS code: ______________ ☐ Bilateral ☐ Left ☐ Right ☐ Initial ☐ Revision

Procedure/Service: ______________________ CPT/HCPCS code: ______________ ☐ Bilateral ☐ Left ☐ Right ☐ Initial ☐ Revision

Procedure/Service: ______________________ CPT/HCPCS code: ______________ ☐ Bilateral ☐ Left ☐ Right ☐ Initial ☐ Revision

(Please check service being requested.) **QUESTION**	**YES**	**NO**	**COMMENTS/NOTES**
A. ☐ **Revision Total Ankle Arthroplasty (TAA):** 1. Is revision TAA (Total Ankle Arthroplasty) being requested due to a failed total ankle prosthesis?	☐	☐	
B. ☐ **Initial Total Ankle Arthroplasty / Replacement:** 1. Is the patient skeletally mature?	☐	☐	
2. Does the patient have moderate or severe pain with loss of ankle mobility and function?	☐	☐	
3. Does the patient have osteoarthritis (degenerative arthritis), post-traumatic arthritis, or rheumatoid arthritis in the affected ankle?	☐	☐	
4. Has the patient failed at least 6 months of conservative management, including physical therapy, non-steroidal anti-inflammatory drugs, and orthoses as indicated?	☐	☐	
5. Does the patient have arthritis in adjacent joints (i.e., subtalar or midfoot), inflammatory (e.g., rheumatoid) arthritis, arthrodesis of the contralateral ankle, or severe arthritis of the contralateral ankle?	☐	☐	

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Name (Last, First MI):	DOB:	Age:	PEHP ID #:

QUESTION (*cont'd*)	YES	NO	COMMENTS/NOTES
6. Which FDA approved artificial ankle prosthesis or implant will be used? *Please check.* ***Product selection is mandatory.*** a. ☐ Agility LP™ Total Ankle b. ☐ Eclipse ™ Total Ankle c. ☐ INBONE™ Total Ankle d. ☐ STAR (Scandinavian Total Ankle Replacement) System e. ☐ Salto Talaris® Ankle Prosthesis f. ☐ Zimmer Trabecular Metal Total Ankle g. ☐ Other (*please specify*): _____	☐	☐	
7. Does the patient have any of the following conditions that are contraindicated for TAA? *Please check all that apply.* a. ☐ Absence of the medial or lateral malleolus b. ☐ Active or prior deep infection in the ankle joint or adjacent bones c. ☐ Avascular necrosis of the talus d. ☐ Charcot Joint e. ☐ Hindfoot or forefoot mal-alignment precluding plantigrade foot f. ☐ Insufficient bone or musculature such that proper component positioning or alignment is not possible g. ☐ Insufficient ligament support that cannot be repaired with soft tissue stabilization h. ☐ Lower extremity vascular insufficiency i. ☐ Neuromuscular disease resulting in lack of normal muscle function about the affected ankle j. ☐ Osteonecrosis k. ☐ Peripheral neuropathy l. ☐ Poor skin and soft tissue quality about the surgical site m. ☐ Prior arthrodesis (fusion) at the ankle joint n. ☐ Prior surgery or injury that has adversely affected the affected ankle bone quality o. ☐ Psychiatric problems that hinder adequate cooperation during peri-operative period p. ☐ Severe anatomic deformity in adjacent ankle structures, including hindfoot, forefoot and knee joint q. ☐ Severe ankle deformity (e.g., severe varus or valgus deformity) that would not normally be eligible for ankle arthroplasty r. ☐ Severe osteoporosis, osteopenia or other conditions resulting in poor bone quality as this may result in inadequate bony fixation s. ☐ Significant mal-alignment of the knee joint t. ☐ Skeletal maturity not yet reached u. ☐ Vascular insufficiency in the affected limb	☐	☐	
8. Will the total ankle arthroplasty/replacement procedure be customized to the individual using any of the following? *Please check all that apply.* a. ☐ Customized, individual-specific ankle implant b. ☐ Customized templates, and/or instrumentation c. ☐ Gender specific implant	☐	☐	

Additional Comments:

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