PEHP Health & Benefits

PRIOR AUTHORIZATION for UVULOPALATOPHARYNGOPLASTY (UPPP)

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:

Provider 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 #:**

Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**

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

Procedure/Service: _____ CPT/HCPCS code: _____

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Procedure/Service: _____ CPT/HCPCS code: _____

Procedure/Service: _____ CPT/HCPCS code: _____

QUESTION	YES	NO	COMMENTS/NOTES
1. Has the patient had either a facility-based or home-based sleep study (Polysomnography)?	☐	☐	*Please submit sleep study report.*
2. Was the facility based or home-based sleep study (polysomnography/PSG) positive with diagnosis of obstructive sleep apnea (OSA) being confirmed?	☐	☐	
2. a. Was the apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) greater than or equal to 15 events/hour with a minimum of 30 events?	☐	☐	
2. b. Was AHI or RDI greater than or equal to 5 and less than 15 events per hour with a minimum of 10 events ***AND*** at least one of the following? *Please check all that apply.* ☐ Documented history of stroke (Cerebrovascular Accident/CVA) ☐ Documented hypertension (systolic blood pressure > 140 and/or diastolic blood pressure > 90) ☐ Documented ischemic heart disease ☐ Documented symptoms of impaired cognition, mood disorders, or insomnia ☐ Excessive daytime sleepiness (documented Epworth score greater than 10) ☐ Greater than 20 episodes of oxygen desaturation (less than 85%) during a full night sleep study ☐ One episode of oxygen desaturation less than 70%	☐	☐	
3. Was the patient prescribed CPAP (Continuous Positive Airway Pressure) or AutoPAP (Auto-Titrating Positive Airway Pressure)?	☐	☐	
4. Did CPAP or AutoPAP relieve patient's symptoms, but the patient was intolerant of CPAP or AutoPAP? **Medical records must document that the patient has attempted CPAP or AutoPAP before considering surgery.*	☐	☐	

Additional Comments:

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