

## PRIOR AUTHORIZATION for VAGUS NERVE STIMULATION (VNS)

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 #:
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### Section II: PROVIDER INFORMATION

Date Requested:	Ordering Provider/Physician:	Ordering Provider/Physician NPI #:	Ordering Provider/Physician Tax ID #:
Ordering Provider/Physician Contact Person:		Ordering Provider/Physician Phone: (        )	Ordering Provider/Physician Facsimile: (        )
Rendering Provider/Facility and Address:		Rendering Provider/Facility NPI #:	Rendering Provider/Facility Tax ID #:
Rendering Provider/Facility Contact Person:	Rendering Provider/Facility Phone: (        )		Rendering Provider/Facility Facsimile: (        )

### Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: <i>Please check.</i>	Requested Date of Service:	Place of Service: <i>Please check.</i>
<input type="checkbox"/> Auth Extension <input type="checkbox"/> Pre-Auth <input type="checkbox"/> Retro Auth <input type="checkbox"/> Urgent		<input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Inpatient <input type="checkbox"/> Office <input type="checkbox"/> Outpatient
Primary Diagnosis/ICD-10 Code:		Secondary Diagnosis/ICD-10 Code:

A. If Vagal Nerve Stimulator (VNS) being requested for any of the following type so epilepsy/seizure disorder? <i>Please check.</i>			
1. <input type="checkbox"/> Atonic Seizures ("drop seizures")           2. <input type="checkbox"/> Dravet Syndrome (Severe Myoclonic Epilepsy of Infancy)           3. <input type="checkbox"/> Focal Seizures (Partial Onset Seizures) 4. <input type="checkbox"/> Generalized Epilepsy Syndrome           5. <input type="checkbox"/> Generalized Motor Seizures (Generalized Tonic-Clonic Seizures)           6. <input type="checkbox"/> Generalized Treatment-Resistant Epilepsy 7. <input type="checkbox"/> Juvenile Myoclonic Epilepsy/JME           9. <input type="checkbox"/> Lennox-Gastaut Syndrome (LGS)           10. <input type="checkbox"/> Status Epilepticus/SE			
B. Type of VNS Requested: <i>Please check.</i>		C. VNS Service Requested: <i>Please check.</i>	
1. <input type="checkbox"/> Vagus Nerve Electrical Stimulator           2. <input type="checkbox"/> Transcutaneous VNS		<input type="checkbox"/> Removal <input type="checkbox"/> Replacement <input type="checkbox"/> Revision	
D. Status of Current VNS: <i>Please check.</i>			
<input type="checkbox"/> Unrepairable <input type="checkbox"/> Warranty Expired			

Service (s) Requested: <i>Please list all requested services/CPT codes regardless of pre-auth requirement.</i>	CPT/HCPCS code:
Procedure/Service:	CPT/HCPCS code:
Procedure/Service:	CPT/HCPCS code:
Procedure/Service:	CPT/HCPCS code:

QUESTION				YES	NO	COMMENTS/NOTES
1. Does the patient have partial onset seizures ( <i>also known as focal seizures</i> ) or Lennox-Gastaut Syndrome (LGS)?				<input type="checkbox"/>	<input type="checkbox"/>	
1. a. Is vagus nerve stimulator/VNS being requested to shorten duration or reduce the severity of seizures?				<input type="checkbox"/>	<input type="checkbox"/>	
1. b. Does the patient remain refractory despite optimal anti-epileptic medications?				<input type="checkbox"/>	<input type="checkbox"/>	
1. c. Does the patient have debilitating side effects from anti-epileptic medications?				<input type="checkbox"/>	<input type="checkbox"/>	
1. d. Does the patient remain refractory despite surgical intervention, such as lesionectomy, medial temporal lobectomy, corpus callosotomy, or lesional epilepsy surgery?				<input type="checkbox"/>	<input type="checkbox"/>	
1. e. Does the patient have a history of bilateral or left cervical vagotomy?				<input type="checkbox"/>	<input type="checkbox"/>	
2. Is vagus nerve stimulation being requested for any of the following conditions? <i>Please check all that apply.</i>						
<input type="checkbox"/> Addiction <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Autism <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Bulimia Nervosa <input type="checkbox"/> Cancer <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Chronic Headaches <input type="checkbox"/> Cluster Headaches <input type="checkbox"/> Coma <input type="checkbox"/> Depression <input type="checkbox"/> Dysphagia <input type="checkbox"/> Essential Tremor <input type="checkbox"/> Eating Disorder (e.g., anorexia) <input type="checkbox"/> Hemicrania Continua <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Gastroparesis <input type="checkbox"/> Heart Failure <input type="checkbox"/> Migraine Headache <input type="checkbox"/> Impaired Glucose Tolerance/Pre-Diabetes <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Inflammation <input type="checkbox"/> Obsessive-Compulsive Disorder <input type="checkbox"/> Mood Disorder <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Obesity <input type="checkbox"/> Prader-Willi Syndrome <input type="checkbox"/> Sleep Disorder <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Post-Traumatic Stress Disorder <input type="checkbox"/> Sjogren's Syndrome <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Tourette's Syndrome <input type="checkbox"/> Vestibular Migraine				<input type="checkbox"/>	<input type="checkbox"/>	

Additional Comments:

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