PRIOR AUTHORIZATION for WEARABLE CARDIOVERTER-DEFIBRILLATORS

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 ☐ Retrospective Auth ☐ Urgent	**Requested Authorization Period:**
Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**

Durable Medical Equipment (DME) Requested:

DME Description: _____ HCPCS code: _____ ☐ Purchase ☐ Rental ☐ Replacement
DME Description: _____ HCPCS code: _____ ☐ Purchase ☐ Rental ☐ Replacement
DME Description: _____ HCPCS code: _____ ☐ Purchase ☐ Rental ☐ Replacement

QUESTION	YES	NO	COMMENTS/NOTES
1. Is there a documented episode of Ventricular Fibrillation/VF that was either spontaneous or induced during an electrophysiologic study? Date: _____	☐	☐	
1. a. Was the documented episode of VF due to a transient or reversible cause or following an acute myocardial infarction/AMI?	☐	☐	
2. Is there a documented episode of sustained Ventricular Tachycardia/VT, lasting 30 seconds or longer, that was either spontaneous or induced during an electrophysiologic study? Date: _____	☐	☐	
2. a. Was the documented episode of VT due to a transient or reversible cause or following an acute myocardial infarction/AMI?	☐	☐	
3. Is the patient awaiting heart transplantation?	☐	☐	
4. Does the patient have a systemic infectious process or other temporary condition that precludes ICD implantation? Contraindication *(please specify):* _____	☐	☐	
5. Does the patient need explantation (removal) of a previously implanted defibrillator?	☐	☐	
6. Does the patient have a documented history of prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular ejection fraction/LVEF less than or equal to 35%?	☐	☐	*Please submit most recent echocardiogram report.*
7. Does the patient have non-ischemic dilated cardiomyopathy and a measured left ventricular ejection fraction/LVEF less than or equal to 35%?	☐	☐	*Please submit most recent echocardiogram report.*
8. Does the patient have a familial or inherited condition with a high risk of life-threatening VT such as long QT syndrome hypertrophic cardiomyopathy, or arrhythmogenic right ventricular cardiomyopathy (ARVC)?	☐	☐	
9. Is the wearable cardioverter-defibrillator (WCD) being used as a bridge until an implantable cardioverter-defibrillator (ICD) can be scheduled? If "*yes*", when is the procedure scheduled? Date: _____	☐	☐	
10. Is the wearable cardioverter-defibrillator (WCD) being used after a CABG (Coronary Artery Bypass Graft), PTCA (Percutaneous Transluminal Coronary Angioplasty, or AMI (Acute Myocardial Infarction)?	☐	☐	

Additional Comments:

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