Harvard Pilgrim Health Care

Implantable Neurostimulators
Medicare Advantage Prior Authorization Request Form — Fax: 866-874-0857

ONLY COMPLETED FORMS CAN BE PROCESSED
Harvard Pilgrim reserves the right to request additional clinical information.
Incomplete forms or lack of supporting documentation may delay response time.

Please check the box below only if request meets the definition of "expedited."

☐ Expedited: Medicare defines expedited requests as those where "applying the standard time for making a determination could seriously jeopardize the enrollee's health, life, or ability to regain maximum function."

Patient Information	**Person Completing Form**
Patient name:	Name:
HPHC member ID #:	Phone #:
Date of birth:	Fax #:
Requesting Provider	**Servicing Provider/Facility**
Name:	Name:
HPHC provider ID #:	Address:
NPI #:	
Date of service:	HPHC provider ID # (*if known*)
Diagnosis:	Tax ID #:
ICD-10 code:	
Service type: ☐ Inpatient ☐ Outpatient ☐ Other	Number of visits/units requested:
Service location:	Authorization type:

Procedure code(s) — *Check all codes that apply*:

☐ 43647	☐ 61864	☐ 61880	☐ 63655	☐ 64561	☐ 64595
☐ 43881	☐ 61867	☐ 61885	☐ 63685	☐ 64575	☐ 95970
☐ 43882	☐ 61868	☐ 61886	☐ 64550	☐ 64581	☐ 95971
☐ 61850	☐ 61870	☐ 61888	☐ 64553	☐ 64585	☐ 95972
☐ 61860	☐ 61875	☐ 63650	☐ 64555	☐ 64590	☐ 95973
☐ 61863					

If you have any questions about this process, please contact the Medicare Advantage Provider Service Center at **888-609-0692.**

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Stimulator	Criteria (check all that apply)
Deep Brain Stimulator	Member with medically refractory essential tremor Member age 7 years or older requires treatment of intractable primary dystonia, including generalized and/or segmental dystonia, hemidystonia, and cervical dystonia (torticollis) Member with medically intractable Parkinson's disease including ***all*** the following: • Levadopa responsive • Motor complications refractory to pharmacologic therapy • Score of 30+ points on motor portion of the Unified Parkinson • Disease Rating Scale when the member has been without medication for approximately 12 hours
Gastric Stimulation for Gastroparesis	Condition is refractory to prokinetic and antiemetic medications Use of prokinetic and antiemetic medications is contraindicated (documentation required.) Scintigraphy confirms delayed gastric emptying
Sacral Nerve Stimulation Temporary Permanent	**For urinary incontinence:** • Urinary incontinence or frequency (confirmed by documentation) • Positive peripheral nerve evaluation test for urinary urge incontinence and urinary urgency/frequency • Diagnosis of refractory urge incontinence, urge/frequency incontinence or non-obstructive urinary retention unrelated to a neurologic condition • Failure of, or symptoms refractory to, at least two types of conservative therapies, (e.g. medication, exercises) • Trial of a temporary sacral nerve stimulator with at least a 50% reduction in (check all that apply): ☐ Urinary retention (catheter volume/catheterization) ☐ Daily incontinence episodes ☐ Severity of the episodes or the number of pads/diapers used per day ☐ Number of voids daily ☐ Volume per void ☐ Frequency per void **For fecal incontinence:** • More than 2 episodes of fecal incontinence per week for 6 months • More than 2 episodes of fecal incontinence per week for 12 months following vaginal childbirth • Failure of conservative therapies, (e.g., medication, dietary modification) • Symptoms refractory to conservative therapies • Successful trial of a temporary sacral nerve stimulator defined as at least a 50% improvement in symptoms (if requesting permanent)

Continued

Spinal Cord Stimulation for Pain ☐ Temporary ☐ Permanent	☐ Chronic intractable neuropathic pain of trunk and limbs ☐ Failure of at least 6 months of conservative treatment (e.g., pharmacotherapy, physical therapy, and/or surgery) ☐ Contraindication to conservative treatment (documentation required) ☐ Neuropathic pain (e.g., failed back surgery syndrome, complex regional pain syndrome, phantom limb/stump pain and peripheral neuropathy) ☐ Successful trial of a temporary spinal cord stimulator defined as at least a 50% improvement in pain relief (if requesting permanent)
Vagal Nerve Stimulator	☐ Member with refractory seizures and persistent seizures ☐ Intolerable side effects after trials of 2 or more antiepileptic mediations ☐ Failed resective surgery or is not a candidate for resective surgery (documentation required)
Describe previous treatments, contraindications and outcomes, if applicable.	
I attest that this form has been completed by me or my designee and that all information is true and correct.	MD Name