

Review Request for Implantable Infusion Pumps

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Policy Last Review Date: 08/28/08	Policy Effective Date: 10/01/08	Provider Tool Effective Date: 8/10/09
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Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:

Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Facility Name:	Facility ID Number:
Facility Address:	

Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Service Requested (CPT if known):	
Diagnosis (ICD-9) if known:	

Please check all that apply to the member:

- Request is for an implantable infusion pump to deliver drugs for the treatment of specific conditions
- Request is for a permanently implanted intrathecal infusion pump for the administration of opiates or non-opiate analgesics for the treatment of:
 - Chronic intractable malignant pain
 - Chronic intractable non-malignant pain
- Request is for a temporary trial of intrathecal infusion pump for the administration of opiates or non-opiate analgesics for the treatment of:
 - Chronic intractable malignant pain
 - Chronic intractable non-malignant pain

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- Request is for infusion of heparin for thromboembolic disease
- Request is for infusion of antibiotics for osteomyelitis
- Request is for a fully implantable insulin pump
- Other: _____

Member has the following conditions: (check all that apply)

- Primary liver cancer (intrahepatic artery injection of chemotherapeutic agents)
- Metastatic colorectal cancer where metastases are limited to the liver (intrahepatic artery injection of chemotherapeutic agents)
- Head/neck cancers (Intra-arterial injection of chemotherapeutic agents)
- Severe, refractory spasticity of cerebral or spinal cord origin in member who is unresponsive to or who cannot tolerate oral baclofen (Lioresal®) therapy (intrathecal injection of baclofen)
- Strong opioids or other analgesics in adequate doses, with fixed schedule (not PRN) dosing have failed to relieve pain or intolerable side effects to systemic opioids or other analgesics have developed
- Life expectancy is greater than 3 months
- Tumor encroachment on the thecal sac has been ruled out by appropriate testing
- No contraindications to implantation exist such as sepsis or coagulopathy
- A temporary trial of spinal (epidural or intrathecal) opiates or non-opiate analgesics has been successful prior to permanent implantation as defined by a 50% reduction in pain
- There is documentation in the medical records of improved function as a result of a temporary trial of an intrathecal infusion pump
- Pain has a duration of greater than 6 months
- Documentation of the failure of 6 months of other conservative treatment modalities (pharmacologic, surgical, psychological, or physical), if appropriate and not contraindicated
- Intractable pain secondary to a disease state with objective documentation of pathology in the medical record
- Further surgical intervention is not indicated
- Psychological evaluation has been obtained and evaluation unequivocally states that the pain is not psychological in origin and that benefit would occur with implantation
- Other: _____

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: _____
- By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name and Title of Provider or Provider Representative
Completing Form (Please Print)*

Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**