



## Authorization Request Form - Part 2 Computerized Tomography Angiography (CTA)

Complete and fax the clinical worksheet immediately following the authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

Please fill in each question option completely  →

<b>Patient Information</b>	First name	Last name
	Member ID	Date of birth (MM/DD/YYYY)

Fill out the following section if submitting for any of the following: **Ventricular Arrhythmia, Supraventricular Tachycardia**

<b>Question 1</b>	Has an MRI been requested for any of the indications listed above? <input type="radio"/> Yes <input type="radio"/> No
<b>Question 2</b>	Does the patient have any of the following? <input type="checkbox"/> Non-rate controlled atrial fibrillation <input type="checkbox"/> Confirmed or suspected pregnancy <input type="checkbox"/> Impaired renal function <input type="checkbox"/> None of the above <input type="checkbox"/> Contrast dye allergy

Fill out the following section ONLY if submitting for any of the following: **Ventricular Arrhythmia**

<b>Question 1</b>	Is this CT Scan for any of the following reason? (select ALL that apply) <input type="checkbox"/> Suspected structural heart disease where other imaging modalities have not defined anatomical structures successfully <input type="checkbox"/> For pre-procedural evaluation of cardiac anatomy for planning of pacing or defibrillator implantation. <input type="checkbox"/> To assess cardiac function (i.e., ejection fraction) in patient evaluation for Implantable Cardioverter-Defibrillator (ICD) implant. <input type="checkbox"/> None of the above
<b>Question 2</b>	Does this patient currently use metformin? <input type="radio"/> Yes <input type="radio"/> No

Fill out the following section ONLY if submitting for any of the following: **Supraventricular Tachycardia**

<b>Question 1</b>	Has an MRI been requested for any of the indications listed above? <input type="radio"/> Yes <input type="radio"/> No
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### Patient Information

First name	Last name
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Fill out the following section if submitting for any of the following: **Peripheral Venous Disease**

<b>Question 1</b>	<p>Which of the following did the patient present with at the last encounter?</p> <p><input type="checkbox"/> Heaviness <input type="checkbox"/> Itching <input type="checkbox"/> Swelling or edema <input type="checkbox"/> Pain, aching, or throbbing <input type="checkbox"/> Skin Family history of peripheral venous disease (e.g., lower extremity vein disease, deep vein thrombosis, superficial thrombophlebitis, lower extremity varicose veins)</p> <p><input type="checkbox"/> The patient is on hormone therapy (e.g., oral contraceptive therapy, HRT) <input type="checkbox"/> The patient frequently sits or stands for long periods <input type="checkbox"/> History of deep vein thrombosis <input type="checkbox"/> History of malignancy (e.g., solid tumors) <input type="checkbox"/> None of the above</p>
<b>Question 2</b>	<p>Which of the following physical exam findings were documented at the last encounter?</p> <p><input type="checkbox"/> Skin discoloration <input type="checkbox"/> Hair loss <input type="checkbox"/> Dry skin <input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> Superficial thrombophlebitis <input type="checkbox"/> Skin ulcers <input type="checkbox"/> None of the above</p>
<b>Question 3</b>	<p>Which of the following conditions were documented at the most recent encounter?</p> <p><input type="checkbox"/> Deep vein thrombosis (i.e., suprainguinal venous thrombosis) <input type="checkbox"/> Venous compression (e.g., tumor, lymphadenopathy) <input type="checkbox"/> Venous malformations (e.g., fistulae)</p> <p><input type="checkbox"/> Suspected pelvic pathology (e.g., uterine fibroids, lymphadenopathy or enlarged lymph nodes) <input type="checkbox"/> None of the above</p>
<b>Question 4</b>	<p>Why is the CTA needed for the patient?</p> <p><input type="checkbox"/> To assess for the presence of suprainguinal pathology <input type="checkbox"/> To delineate the venous anatomy (e.g., pre-procedure planning, post-procedure follow-up)</p> <p><input type="checkbox"/> A venous duplex scan was inadequate to confirm the diagnosis <input type="checkbox"/> None of the above</p>
<b>Question 5</b>	<p>Does the patient have any of the following risk factors?</p> <p><input type="checkbox"/> An acute venous condition (e.g., superficial or deep thrombophlebitis) <input type="checkbox"/> The patient is pregnant <input type="checkbox"/> Severe allergy to contrast media</p> <p><input type="checkbox"/> Severe renal insufficiency <input type="checkbox"/> The patient takes metformin <input type="checkbox"/> None of the above</p>



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### Patient Information

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Fill out the following section if submitting for any of the following: **Murmurs**

#### Question 1

Which of the following findings were documented at the most recent encounter?

- |  |  |
|--|--|
| <input type="checkbox"/> New or worsening dyspnea with known or suspected valvular heart disease   | <input type="checkbox"/> Known or suspected pulmonary arterial hypertension                                |
| <input type="checkbox"/> New or worsening dyspnea with known or suspected pulmonary disease.   | <input type="checkbox"/> Abnormal transthoracic echocardiogram findings that need further characterization |
| <input type="checkbox"/> An extrathoracic disease that may involve the heart (e.g., sarcoidosis, amyloidosis, cancer)                                  | <input type="checkbox"/> None of the above   |
| <input type="checkbox"/> Known or suspected cardiovascular abnormalities, congenital or acquired (e.g., aortic stenosis, aortic aneurysms, dissection) |  |

#### Question 2

Does the patient have any of the following?

- |   |   |
|---|---|
| <input type="checkbox"/> Chest pain with a high probability of ischemic disease | <input type="checkbox"/> Significant contrast dye allergy |
| <input type="checkbox"/> Nonischemic Myocardial Disease                         | <input type="checkbox"/> The patient takes metformin      |
| <input type="checkbox"/> Renal failure  | <input type="checkbox"/> None of the above                |



## Authorization Request Form - Part 2 Chest Computerized Tomography (CT)

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Please fill in each question option completely  →

<b>Patient Information</b>	First name	Last name
	Member ID	Date of birth (MM/DD/YYYY)

Fill out the following section if submitting for any of the following: **Aortic Disease**

<b>Question 1</b>	<b>Is this the first request for CT Chest for this patient?</b> <input type="radio"/> Yes, this is the first request for CT Chest. <input type="radio"/> No, this is a follow-up or serial imaging request for this patient.
<b>Question 2</b>	<b>Has the patient been documented to have any of the following findings?</b> <input type="checkbox"/> An X-ray (or another imaging study) suggests thoracic aortic pathology <input type="checkbox"/> Other condition that increases the risk of aneurysmal degeneration of the aorta <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> Signs or symptoms suggesting the presence of a thoracic or thoracoabdominal aortic aneurysm <input type="checkbox"/> Ehlers-Danlos syndrome <input type="checkbox"/> None of the above <input type="checkbox"/> Turner syndrome
<b>Question 3</b>	<b>What type of aneurysm is the patient documented to have?</b> <input type="checkbox"/> Degenerative aortic root <input type="checkbox"/> Descending aortic aneurysm <input type="checkbox"/> Ascending aortic aneurysm <input type="checkbox"/> Not applicable, the patient has not been documented to have an aneurysm. <input type="checkbox"/> Genetically mediated aortic root <input type="checkbox"/> None of the above
<b>Question 4</b>	<b>What is the maximum diameter of the aorta (to the nearest decimal point)?</b> <input type="radio"/> Greater than 6.0 cm <input type="radio"/> 4.0 - 4.4 cm <input type="radio"/> 5.1 - 5.4 cm <input type="radio"/> 3.5 - 3.9 cm <input type="radio"/> 5.0 cm <input type="radio"/> 3.0 - 3.4 cm <input type="radio"/> 4.5 - 4.9 cm <input type="radio"/> None of the above or not applicable
<b>Question 5</b>	<b>Does the patient require follow-up to detect aneurysmal degeneration of a previously dissected aortic segment?</b> <input type="radio"/> Yes <input type="radio"/> No
<b>Question 6</b>	<b>Does the patient have any of the following?</b> <input type="checkbox"/> Non-compatible implanted devices <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Metallic intraocular foreign bodies <input type="checkbox"/> Patient is pregnant <input type="checkbox"/> The patient has IV contrast dye hypersensitivity <input type="checkbox"/> None of the above <input type="checkbox"/> The patient has impaired renal function, and angiographic contrast is utilized for the study.



## Authorization Request Form - Part 2 Computerized Tomography Angiogram (CTA) (with Run-off)

Complete and fax the clinical worksheet immediately following the authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

 Please fill in each question option completely  →

### Patient Information

First name	Last name
Member ID	Date of birth (MM/DD/YYYY)

Fill out the following section if submitting for any of the following: **Peripheral Arterial Disease**

<b>Question 1</b>	Has the patient failed to show significant clinical improvement (e.g. improved pain free walking distance) despite compliance with best medical therapy and an exercise program? <input type="radio"/> Yes <input type="radio"/> No
<b>Question 2</b>	Have the patient's symptoms limited their activities of daily living (ADL)? <input type="radio"/> Yes <input type="radio"/> No
<b>Question 3</b>	Has the patient attempted smoking cessation? <input type="checkbox"/> Not applicable, the patient is not a smoker. <input type="checkbox"/> No, the patient is an active smoker with no plan to quit. <input type="checkbox"/> Yes, the patient has attempted smoking cessation.
<b>Question 4</b>	Is the patient being considered for revascularization? <input type="radio"/> Yes <input type="radio"/> No
<b>Question 5</b>	Does the patient have any of the following risk factors? <input type="checkbox"/> Symptoms of acute PAD or critical limb ischemia (e.g., ulcers, rest pain) <input type="checkbox"/> The patient takes metformin <input type="checkbox"/> The patient is pregnant <input type="checkbox"/> The area to be imaged has heavy arterial calcification <input type="checkbox"/> Severe allergy to contrast media <input type="checkbox"/> None of the above <input type="checkbox"/> Severe renal insufficiency



## Authorization Request Form - Part 2

### Computerized Tomography (CT) Abdomen and Pelvis & Computerized Tomography (CT) Aorta and Iliofemoral Arteries

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 Please fill in each question option completely  →

#### Patient Information

First name	Last name
Member ID	Date of birth (MM/DD/YYYY)

Fill out the following section if submitting for any of the following: **Aortic Disease: Computerized Tomography (CT) Abdomen and Pelvis, Computerized Tomography (CT) Aorta and Iliofemoral Arteries**

<b>Question 1</b>	Has the patient been imaged previously by a duplex ultrasound? <input type="radio"/> Yes <input type="radio"/> No
<b>Question 2</b>	Did the previous duplex ultrasound adequately assess the aorta or iliac arteries? <input type="radio"/> Yes <input type="radio"/> No
<b>Question 3</b>	Does the patient have characteristics (e.g., morbid obesity) where duplex ultrasound is not expected to provide adequate information? <input type="radio"/> Yes <input type="radio"/> No

Fill out the following section if submitting for any of the following: **Aortic Disease: Computerized Tomography (CT) Aorta and Iliofemoral Arteries**

<b>Question 1</b>	Does the clinician require detailed images of the arterial anatomy for diagnosis or treatment? <input type="radio"/> Yes <input type="radio"/> No
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 Please fill in each question option completely  →

<b>Patient Information</b>	First name	Last name
	Member ID	Date of birth (MM/DD/YYYY)

Fill out the following section if submitting for any of the following: **Cardiomyopathies**

<b>Question 1</b>	<p>Does the patient have any of the following?</p> <table><tr><td><input type="checkbox"/> Presence of cardiothoracic conditions that may be the cause of the cardiomyopathy (e.g., cancer, sarcoidosis, pericardial disease, amyloidosis)</td><td><input type="checkbox"/> Echocardiography did not adequately image the cardiac chambers valves, great vessels, and pericardium.</td></tr><tr><td><input type="checkbox"/> The cardiomyopathy would be better defined by imaging the lungs or thorax (e.g., amyloidosis, sarcoidosis.)</td><td><input type="checkbox"/> None of the above</td></tr></table>	<input type="checkbox"/> Presence of cardiothoracic conditions that may be the cause of the cardiomyopathy (e.g., cancer, sarcoidosis, pericardial disease, amyloidosis)	<input type="checkbox"/> Echocardiography did not adequately image the cardiac chambers valves, great vessels, and pericardium.	<input type="checkbox"/> The cardiomyopathy would be better defined by imaging the lungs or thorax (e.g., amyloidosis, sarcoidosis.)	<input type="checkbox"/> None of the above
<input type="checkbox"/> Presence of cardiothoracic conditions that may be the cause of the cardiomyopathy (e.g., cancer, sarcoidosis, pericardial disease, amyloidosis)	<input type="checkbox"/> Echocardiography did not adequately image the cardiac chambers valves, great vessels, and pericardium.				
<input type="checkbox"/> The cardiomyopathy would be better defined by imaging the lungs or thorax (e.g., amyloidosis, sarcoidosis.)	<input type="checkbox"/> None of the above				
<b>Question 2</b>	<p>Did the patient have a recently requested MRI for the same indications?</p> <p><input type="radio"/> Yes      <input type="radio"/> No</p>				