



Authorization Request Form - Part 2 Electrical Cardioversion, Elective

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.

i 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: **Atrial Fibrillation**

Question 1	<p>Is the patient scheduled for any of the following procedures?</p> <p><input type="checkbox"/> Symptomatic Premature Ventricular Complexes (PVCs) in a patient refractory to or intolerant to antiarrhythmic therapy</p> <p><input type="checkbox"/> High-frequency Premature Ventricular Complexes (PVCs) with symptoms or diminished left ventricular (LV) function (LVEF less than or equal to 50%)</p>																			
Question 2	<p>Which of the following findings were documented within the past three months?</p> <p><input type="checkbox"/> Infrequent nonsustained ventricular tachycardia (VT)</p> <p><input type="checkbox"/> Torsades de Pointes or other sustained polymorphic ventricular tachycardia (VT)</p> <p><input type="checkbox"/> Patient has experienced a ventricular fibrillation (VF) arrest.</p> <p><input type="checkbox"/> None of the above</p> <p><input type="checkbox"/> Option</p> <p><input type="checkbox"/> Option</p>																			
Question 3	<p>Has the patient had a minimum of 3-4 weeks of therapeutic anticoagulant therapy?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>																			
Question 4	<p>Is this patient documented to have permanent atrial fibrillation?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>																			
Question 5	<p>Is rate control the primary management strategy for this patient's atrial fibrillation?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>																			
Question 6	<p>Does the patient have any of the following surgical risk factors? (additional information)</p> <table border="0"> <tr> <td><input type="checkbox"/> Active bacterial infection</td> <td><input type="checkbox"/> Active smoking/nicotine use: enroll patient in a smoking cessation program</td> <td><input type="checkbox"/> Active drug or alcohol abuse</td> <td rowspan="6"> Cardiovascular Disease (any of the following): acute coronary symptoms, uncompensated Congestive Heart Failure (CHF), uncontrolled arrhythmia, uncontrolled hypertension (greater than 180/110 mm Hg), severe valvular disease, percutaneous coronary intervention (PCI) within 1 month <input type="checkbox"/> None of the above </td> </tr> <tr> <td><input type="checkbox"/> *Morbid Obesity (BMI greater than 40); refer for weight loss management</td> <td><input type="checkbox"/> Advanced Renal Disease (creatinine greater than 2)</td> <td><input type="checkbox"/> Coagulopathy or on anticoagulant therapy</td> </tr> <tr> <td><input type="checkbox"/> Primary pulmonary hypertension</td> <td><input type="checkbox"/> Anemia – Hemoglobin less than 11 (females 11, males 12)</td> <td><input type="checkbox"/> Diabetes – HbA1c greater than or equal to 8%</td> </tr> <tr> <td><input type="checkbox"/> End Stage Liver Disease</td> <td><input type="checkbox"/> Uncontrolled Seizure Disorder</td> <td><input type="checkbox"/> History of Malignant Hyperthermia/Heat stroke</td> </tr> <tr> <td><input type="checkbox"/> Known allergy or hypersensitivity to medication needed for procedure</td> <td><input type="checkbox"/> Trans Ischemic Attack (TIA) or stroke within past three months</td> <td><input type="checkbox"/> Obstructive Sleep Apnea – NOT treated with CPAP: Refer the patient for Sleep Apnea Treatment</td> </tr> <tr> <td><input type="checkbox"/> Oxygen-dependent pulmonary disease</td> <td></td> <td></td> </tr> </table>	<input type="checkbox"/> Active bacterial infection	<input type="checkbox"/> Active smoking/nicotine use: enroll patient in a smoking cessation program	<input type="checkbox"/> Active drug or alcohol abuse	Cardiovascular Disease (any of the following): acute coronary symptoms, uncompensated Congestive Heart Failure (CHF), uncontrolled arrhythmia, uncontrolled hypertension (greater than 180/110 mm Hg), severe valvular disease, percutaneous coronary intervention (PCI) within 1 month <input type="checkbox"/> None of the above	<input type="checkbox"/> *Morbid Obesity (BMI greater than 40); refer for weight loss management	<input type="checkbox"/> Advanced Renal Disease (creatinine greater than 2)	<input type="checkbox"/> Coagulopathy or on anticoagulant therapy	<input type="checkbox"/> Primary pulmonary hypertension	<input type="checkbox"/> Anemia – Hemoglobin less than 11 (females 11, males 12)	<input type="checkbox"/> Diabetes – HbA1c greater than or equal to 8%	<input type="checkbox"/> End Stage Liver Disease	<input type="checkbox"/> Uncontrolled Seizure Disorder	<input type="checkbox"/> History of Malignant Hyperthermia/Heat stroke	<input type="checkbox"/> Known allergy or hypersensitivity to medication needed for procedure	<input type="checkbox"/> Trans Ischemic Attack (TIA) or stroke within past three months	<input type="checkbox"/> Obstructive Sleep Apnea – NOT treated with CPAP: Refer the patient for Sleep Apnea Treatment	<input type="checkbox"/> Oxygen-dependent pulmonary disease		
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