Authorization Request Form - Part 2
Sacroiliac (SI) Joint Injections

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)

Question 1

How many SI injections has the patient had for this same diagnosis and same side in the past 12 months? (Required, fill in one option)

- ◯ None - this is the first request for an SI joint injection at this site.
- ◯ 1 previous SI joint injection at this site in the past 12 months
- ◯ 2 previous SI joint injections at this site in the past 12 months
- ◯ 3 previous SI joint injections at this site in the past 12 months
- ◯ 4 or more previous SI joint injections at this site in the past 12 months

Question 2

Which of the following findings were documented at the most recent encounter? (Required, fill in all that apply)

- ☐ Low back pain
- ☐ Localized pain over the sacroiliac (SI) joint (ex. Fortin's point)
- ☐ Lower extremity pain (radicular pain)
- ☐ Paresthesia (burning or prickling sensation in extremities)
- ☐ Numbness in a myotomal or dermatomal distribution
- ☐ Increased pain with coughing, sneezing, or straining
- ☐ Bowel or bladder dysfunction
- ☐ Saddle anesthesia
- ☐ Focal neurologic deficit with progressive, persistent (>1 month), or disabling symptoms
- ☐ Major motor weakness of lower extremities
- ☐ Clinically significant neurological deficit present
- ☐ None of the above

Question 3

What were the positive provocative physical examination findings at the most recent encounter? (Required, fill in all that apply)

- ☐ Positive SI distraction (Gapping)
- ☐ Positive SI compression (Approximation)
- ☐ Positive thigh thrust
- ☐ Positive Gaenslen's
- ☐ Positive Sacral Thrust (Sacral Spring, Downwards Pressure)
- ☐ Positive FABER maneuver (Patrick's)
- ☐ None of the above

Question 4

How long has conservative care occurred consecutively within the past 12 months? (Required, fill in one option)

- ◯ No conservative care occurred
- ◯ 0-11 weeks
- ◯ 12 weeks or greater
- ◯ None of the above

Question 5

What type of conservative care has been attempted? (Required, fill in one option)

- ◯ Physical therapy which includes HEP (home exercise program)
- ◯ Medications
- ◯ Activity/ Lifestyle Modification
- ◯ None of the above

Question 6

What percentage did the previous injection improve symptoms by? (Required, fill in one option)

- ◯ 80% relief or greater
- ◯ 75%-79% relief
- ◯ 50%-74% relief
- ◯ Less than 50% relief
- ◯ Not applicable, the patient did not have a previous injection

Question 7

What duration of symptom relief did the previous injection provide? (Required, fill in one option)

- ◯ 12 weeks or more
- ◯ 6-11 weeks
- ◯ 0-5 weeks
- ◯ Not applicable, the patient did not have a previous injection