Authorization Request Form - **Part 2**

Pain Infusion Pump

Complete and fax the clinical worksheet immediately following the Part 1 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 ⬭ → ⬬

Question 1

Is the patient experiencing pain from one of the following? (Required, fill in one option)

- ⬭ Cancer-related pain, Category 1 (imminent death or short life expectancy)
- ⬭ Cancer-related pain, Category 2 (disease is stable and will likely progress)
- ⬭ Cancer-related pain, Category 3 (partial remission or cured)
- ⬭ Chronic pain (not cancer-related) with diagnosis (from a known cause), neuropathic
- ⬭ Chronic pain (not cancer-related) with diagnosis (from a known cause), mixed
- ⬭ Chronic pain (not cancer-related) with diagnosis (from a known cause), mixed and patient has been treated with neurostimulators or spinal cord stimulators
- ⬭ Spasticity or dystonia
- ⬭ None of the above

Question 2

Has pain persisted, or has the patient experienced side effects, with the following interventions? (Required, fill in all that apply)

- ⬭ Oral, transdermal, or subcutaneous opioids
- ⬭ Treatment directed at underlying condition
- ⬭ Symptoms poorly controlled by medications, or patient unable to tolerate medications
- ⬭ None of the above

Question 3

Has the patient had successful preliminary intrathecal or epidural injection or infusion? (Required, fill in one option)

- ⬭ Yes
- ⬭ No

Question 4

Is the patient's body size adequate to support a pain infusion pump device? (Required, fill in one option)

- ⬭ Yes
- ⬭ No

Question 5

Is the patient able to tolerate the implantation procedure? (Required, fill in one option)

- ⬭ Yes
- ⬭ No

Question 6

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

- ⬭ Painful spasticity
- ⬭ Spasticity or dystonia that increases risk for contractures, pressure sores, or other complications
- ⬭ Spasticity or dystonia that prevents adequate performance of activities of daily living or mobility
- ⬭ None of the above

Question 7

Has the patient had a greater than or equal to 1-point drop in the Ashworth scale of intrathecal injection of baclofen? (Required, fill in one option)

- ⬭ Yes
- ⬭ No

Questions continued on following page

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Please fill in each question option completely ⬭ → ⬬

Question 8

Does the patient have any of the following risk factors? (Required, fill in all that apply)

- ⬭ Acute psychiatric instability or uncontrolled suicide risk
- ⬭ Current infection
- ⬭ Diagnosed substance-related disorder (other than nicotine), or patient currently receiving active treatment for disorder
- ⬭ Known allergy or hypersensitivity to agent being infused
- ⬭ Tumor encroachment of thecal sac
- ⬭ Untreated obstructive sleep apnea
- ⬭ Decreased cardiopulmonary function
- ⬭ None of the above

Question 9

Will the clinician requesting authorization of the pain infusion pump, also be managing the pain therapy? (Optional, fill in one option)

- ⬭ Yes
- ⬭ No

Question 10

Does the surgeon have a preference for where the patient is discharged for post-acute care (if still appropriate at the time of discharge)? (Required, fill in one option)

- ⬭ Discharge home, no post-acute services required
- ⬭ Discharge home, outpatient Physical Therapy services required
- ⬭ Discharge home, Home Health Agency (HHA) services required
- ⬭ Discharge to Skilled Nursing Facility
- ⬭ No discharge preference indicated

Question 11

Did the patient's primary care physician provide preoperative medical clearance for this patient? (Optional, fill in one option)

- ⬭ Yes
- ⬭ No