SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Infuse® Bone Graft

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Contact person name (print)	Telephone number	Fax number
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

Is the member obese (BMI greater than or equal to 35) ☐ Yes ☐ No

Is the member advanced in age (over 65 years of age) ☐ Yes ☐ No

Has the member receieved a previous autograft and is not a candidate for further autograft procedures because the tissue is no longer available ☐ Yes ☐ No

Is morbidity present, preventing harvesting at auto graft donor site such as:

- Infection ☐ Yes ☐ No
- Fracture ☐ Yes ☐ No
- Malignancy ☐ Yes ☐ No

Is the patient's bone of poor quality or has osteoporosis ☐ Yes ☐ No

Is the use of autograft or cadaveric allograft feasible ☐ Yes ☐ No

If yes, rationale _____ ☐ ☐

Will the member have the Infuse® Bone Graft/LT-Cage® lumbar tapered fusion device for spinal fusion procedures in skeletally mature patients with degenerative disc disease:

- Is this only for a single level ☐ Yes ☐ No
- Is this from the second lumbar vertebra (L2) to the first sacral vertebra (S1) ☐ Yes ☐ No
- What is the level the procedure will be done _____

Does the member have degenerative disc disease, defined as disco genic back pain with degeneration of the disc confirmed by patient history and radiographic studies ☐ Yes ☐ No

If yes, date of the x-rays _____

Does the member have less than grade I spondylolithesis at the involved level ☐ Yes ☐ No

Is the Infuse® Bone Graft for an open tibial shaft frature ☐ Yes ☐ No

If yes, date (month/day/year) of fracture _____ /_____ /_____

- Has the fracture stabilized with intramedullary nail fixation after apropriate wound management ☐ Yes ☐ No
- Will the Infuse® Bone Graft be applied within 14 days after the initial fracture ☐ Yes ☐ No
- If not using for tibial shaft fracture, what type of fracture will this be used for _____

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:	Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715-221-6616	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Customer Service at 1-800-548-1224.

