SecurityHealth Plan℠
Promises kept, plain and simple.®

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

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TTY: 711

Cardiac Valve Replacement

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.

MitraClip® procedure ☐ Yes ☐ No

- Member with grade 3+ to 4+ symptomatic degenerative mitral regurgitation ☐ Yes ☐ No
- Member at high-risk for traditional open-heart mitral valve surgery ☐ Yes ☐ No
- Transcatheter mitral valve repair with a device cleared by the U.S. Food and Drug Administration for use in mitral valve repair ☐ Yes ☐ No
- Any documented contraindications present as indicated by all of the following:
  - No active bacterial endocarditis or other active infections within 6 months of surgery ☐ Yes ☐ No
  - No pre-existing prosthetic heart valve failure (e.g. mechanical; animal-based) or prosthetic ring in any position ☐ Yes ☐ No
  - No acute coronary syndrome (e.g. MI, unstable angina pectoris), transient ischemic attack or stroke within one month of surgery ☐ Yes ☐ No
  - No evidence on echocardiogram of intracardiac mass, thrombus, or vegetation ☐ Yes ☐ No
  - No kidney dysfunction classification greater than stage 3 ☐ Yes ☐ No
  - Heart failure symptoms of New York Heart Association class II or greater ☐ Yes ☐ No

Transcatheter aortic valve replacement (TAVR) and TAVI procedure ☐ Yes ☐ No

- Transcatheter aortic valve replacement with the Edwards SAPIEN, SAPIEN XT, or SAPIEN 3 transcatheter heart valve ☐ Yes ☐ No
  - The individual has a calcified aortic valve ☐ Yes ☐ No

– The individual has severe native valve aortic stenosis as demonstrated :
  - Mean aortic valve gradient greater than 40 mm Hg ☐ Yes ☐ No
  - Jet velocity greater than 4.0 m/sec ☐ Yes ☐ No
  - The aortic valve area is less than 0.8 cm_2 ☐ Yes ☐ No
  - The aortic valve area index is less than 0.5 cm_2/m_2 ☐ Yes ☐ No
– The individual has documented heart failure symptoms and is New York Heart Association functional class II or greater ☐ Yes ☐ No
– The individual has an ejection fraction greater than 20% ☐ Yes ☐ No
– The individual is not considered a candidate for open (for example, median sternotomy) aortic valve repair or replacement due to medical factors, as determined by at least two physicians based on predicted probability of death or a serious, irreversible morbidity greater than 50% ☐ Yes ☐ No
– None of the following comorbid conditions or contraindications that would preclude the expected benefit from aortic stenosis correction are present:
  - Abdominal aortic or thoracic aneurysm (defined as maximal luminal diameter 5 cm or greater) ☐ Yes ☐ No
  - Intolerance to anticoagulation/antiplatelet regimen or bleeding dyscrasias (e.g. leucopenia, acute anemia, thrombocytopenia) ☐ Yes ☐ No
  - Hypertrophic cardiomyopathy with or without obstruction ☐ Yes ☐ No
  - Congenital heart valve anomalies including, but not limited to, congenital unicuspid or bicuspid valve ☐ Yes ☐ No

• Transcatheter aortic valve replacement with the CoreValve® system ☐ Yes ☐ No
– The individual has severe degenerative, native valve aortic stenosis demonstrated by one of the following:
  - The aortic valve area is equal to or less than 0.8 cm_2 ☐ Yes ☐ No
  - The aortic valve area index is equal to or less than 0.5 cm_2/m_2 ☐ Yes ☐ No
– The individual has severe degenerative, native valve aortic stenosis demonstrated by one of the following:
  - Mean aortic valve gradient greater than 40 mm Hg ☐ Yes ☐ No
  - Peak aortic jet velocity greater than 4.0 m/sec ☐ Yes ☐ No
– The individual has a native aortic annulus diameter between 18 and 29 mm ☐ Yes ☐ No
– The individual has ejection fraction greater than 20% ☐ Yes ☐ No
– Heart failure symptoms of New York Heart Association Class II or greater ☐ Yes ☐ No
– The individual has comorbidities such that at least three physicians agree that:
  - The predicted risk of operative mortality at 30 days is 15% or greater ☐ Yes ☐ No
  - The predicted risk of operative mortality OR serious, irreversible morbidity at 30 days is less than 50% ☐ Yes ☐ No

– None of the following comorbid conditions or contraindications that would preclude the expected benefit from aortic stenosis correction are present:

- Intolerance to anticoagulation/antiplatelet regimen or bleeding dyscrasias (i.e. leucopenia, acute anemia, thrombocytopenia, gastrointestinal bleeding within past 3 months) ☐ Yes ☐ No
- Hypertrophic obstructive cardiomyopathy ☐ Yes ☐ No
- Congenital bicuspid or unicuspid aortic valve ☐ Yes ☐ No
- Active bacterial endocarditis, echocardiographic evidence of intracardiac mass, thrombus or vegetations, or other active infections ☐ Yes ☐ No
- Severe ventricular dysfunction with left ventricular ejection fraction less than or equal to 20% ☐ Yes ☐ No
- Life expectancy less than 12 months due to non-cardiac comorbid conditions ☐ Yes ☐ No
- Acute myocardial infarction within 1 month of planned TAVR procedure; or cerebral vascular accident or transient ischemic attack within last 6 months ☐ Yes ☐ No
- End stage renal disease requiring chronic dialysis or creatinine clearance less than 20 mL /min ☐ Yes ☐ No
- Mixed aortic valve disease (aortic stenosis and aortic regurgitation with severity [3-4+]) ☐ Yes ☐ No
- Moderate to severe (3-4+) mitral regurgitation ☐ Yes ☐ No
- Moderate to severe mitral stenosis ☐ Yes ☐ No
- Severe (4+) tricuspid regurgitation ☐ Yes ☐ No
- Pre-existing prosthetic heart valve in any position ☐ Yes ☐ No
- Individual was offered surgery but refused ☐ Yes ☐ No

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

