

Blepharoplasty, Blepharoptosis Repair

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: <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Hospital outpatient <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> Provider's office <input type="checkbox"/> Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
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 this for congenital ptosis** (colored frontal photographs and automated visual fields must be submitted at the time of prior authorization request)..... Yes No
- Infant or child has congenital ptosis..... Yes No
 - Ptosis interferes with field of vision..... Yes No
 - Child has abnormal head posture..... Yes No

- Is this for upper eyelid blepharoplasty** (colored frontal photographs and automated visual fields must be submitted at the time of prior authorization request) Yes No
- Does member have any of these symptoms or findings:
 - Prosthesis difficulties in an anophthalmia socket; defects predisposing to corneal or conjunctival irritation Yes No
 - Painful symptoms of blepharospasm refractory to medical management; treat peri-orbital sequelae of thyroid disease and nerve palsy, and periorbital; sequelae of other nerve palsy (e.g. exposure keratitis) Yes No
 - Upper eyelid defect caused by trauma, tumor, or ablative surgery resulting in a severe physical deformity or disfigurement which is causing functional visual impairment Yes No
 - Clinically significant impairment of upper/outer visual fields caused by redundant skin weighing down lashes of the upper eyelid resulting in any one of the following: Difficulty reading due to upper eyelid drooping; looking through the eyelashes; seeing the upper eyelid skin..... Yes No

- Is this for lower eyelid blepharoplasty** (colored frontal photographs and automated visual fields must be submitted at the time of prior authorization request) Yes No

- Does member have any of these symptoms or findings:
- Proper positioning of prescription eyeglasses is precluded **and** is secondary to **any** of the following conditions in association with functional visual impairment: Chronic systemic corticosteroid therapy; dermatomyositis; Graves' disease; myxedema; nephrotic syndrome; polymyositis; scleroderma; Sjögren's syndrome; systemic lupus erythematosus; facial nerve damage Yes No

• Is there functional visual impairment (documented uncontrolled tearing or irritation) and failed conservative treatments Yes No

Is this for blepharoptosis (ptosis) repair (colored straight ahead photographs must be submitted at the time of prior authorization request) Yes No

Does member have any of these symptoms or findings:

- Documented complaints of interference with vision or visual field-related activities, such as difficulty reading or driving due to eyelid position Yes No
- Other causes of ptosis are ruled out (e.g. recent botox injections, myasthenia gravis when applicable) Yes No
- Documentation of a visual field test without the eyelid or brow taped showing points of visual loss inside the twenty-five degree circle of the superior field that is corrected when taped and shows improvement in the superior field with no visual loss inside the forty degree circle of the superior field Yes No

Is this for brow ptosis repair (brow lift) (colored frontal photographs and automated visual fields must be submitted at the time of prior authorization request) Yes No

Does member have any of these symptoms or findings:

- Brow ptosis is causing a functional impairment of upper/outer visual fields with documented interference with vision or visual field related activities such as difficulty reading due to upper eyelid drooping, looking through the eyelashes, or seeing the upper eyelid skin Yes No
- Documentation that includes that the other causes have been eliminated as the primary cause for the visual field obstruction (e.g. Botox® treatments within the past 6 months) Yes No

Is this for extended blepharospasm Yes No

Does member have any of these symptoms or findings:

- Debilitating symptoms (e.g., pain) Yes No
- Conservative treatment has been tried and failed, or is contraindicated (e.g., Botox®) Yes No

Is this for eyelid ectropion or entropion repair (colored frontal photographs must be submitted at the time of prior authorization request) Yes No

Ectropion Yes No

Does member have any of these symptoms or findings:

- Pain or discomfort, excess tearing, exposure keratitis; keratoconjunctivitis; or corneal ulcer ... Yes No

Entropion (eyelid turned inward) Yes No

Does member have any of these symptoms or findings:

- Pain or discomfort, excess tearing, trichiasis; or irritation of cornea or conjunctiva Yes No
- Conservative treatments have been tried and failed Yes No

Is this for eyelid surgery with an anophthalmic socket Yes No

Does member have any of these symptoms or findings:

- Patient has an anophthalmic condition Yes No
- Patient is experiencing difficulties fitting or wearing an ocular prosthesis Yes No

Is this for upper eyelid tightening (colored frontal photographs must be submitted at the time of prior authorization request) Yes No

Does member have any of these symptoms or finding(s):

- Functional impairment Yes No
- Conservative treatments have been tried and failed Yes No
- Simple repair of ectropion or entropion will not correct condition Yes No
- Epiphora (excess tearing) not resolved by conservative measures; corneal dryness unresponsive to lubricants; or corneal ulcer Yes No

Is this for surgical correction of upper and lower eyelid retraction (colored frontal photographs and automated visual fields must be submitted at the time of prior authorization request) Yes No

Does the member having any of these findings:

- 1. There is functional impairment (e.g., dry eyes, pain/discomfort, tearing, blurred vision) Yes No
- 2. Thyroid eye disease, two or more Hertel measurements at least 6 months yes no apart with the same base measurements are unchanged..... Yes No
- 3. Tried and failed conservative treatments..... Yes No

Is this for repair of floppy eyelid syndrome (colored frontal photographs and automated visual fields must be submitted at the time of prior authorization request) Yes No

- 1. Subjective symptoms must include eyelids spontaneously "flipping over" when they sleep due to rubbing on the pillow and one of the following:
Eye pain or discomfort; excess tearing; or eye irritation, ocular redness and discharge Yes No
- 2. Does the member have any of these findings:
Eyelash ptosis; significant upper eyelid laxity; presence of giant papillary conjunctivitis; superficial punctate erosions (SPK); corneal abrasion; or microbial keratitis Yes No
- 3. Documentation that conservative treatment has been tried and failed Yes No

Is this for repair of paralytic lagophthalmos treatments Yes No

Does the member have any of these findings:

- 1. Members are expected to have delayed, incomplete recovery of facial nerve function Yes No
- 2. Have exposed cornea and inadequate lacrimation Yes No
- 3. Have failed conservative treatment (e.g., corneal lubricants, moisture chambers, or taping of lower eyelid). 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 1.800.472.2363.