BlueCross BlueShield of North Carolina

# Prostatic Urethral Lift

## PRIOR REVIEW/CERTIFICATION

## Request for Services Form

Submission of this form is solely a notification for request for services and does not guarantee approval. All requests must be reviewed using authorization requirements by the prospective review area/department before authorization is granted. *Incomplete forms may delay processing. All NC Providers must provide their 5-digit BCBSNC provider ID# below.*

| Patient Name | BCBSNC Member ID number | Patient Date of Birth |
|---|---|---|
| | | |

| **Requesting Provider Information** | | **Servicing Provider or Facility Location (for services to be performed outside of the physician office)** | |
|---|---|---|---|
| Provider Name | | Servicing Provider | |
| Provider #, Tax ID # or NPI | | Facility Name | |
| Street, Bldg., Suite # | | Servicing provider or Facility #, Tax ID # or NPI | |
| City/State/Zip code | | Street, Bldg., Suite # | |
| Phone # | | City/State/Zip code | |
| Fax # | | | |

| | | | |
|---|---|---|---|
| Primary Diagnosis | | ICD-10 Code | |
| Other Diagnosis | | ICD-10 Code | |

| Fill in the appropriate response: Y= Yes; N =No, NA =Not Applicable | |
|---|---|
| 1. | Is request for prostatic urethral lift in individual who is 45 years of age or older **AND** has moderate-to-severe lower urinary tract obstruction due to benign prostatic hyperplasia (BPH)? Y_____ N_____ |
| 2. | The patient is **NOT** a candidate for invasive surgical procedure (such as transurethral resection of prostate) **OR** patient opted for minimally invasive procedure? Y_____ N_____<br>**If yes,**<br>a. Does the patient have persistent or progressive lower urinary tract symptoms? Y_____ N_____<br>b. Has there been an appropriate trial period of medical therapy (defined as one month with an alpha-1-adrenergic antagonist **OR** 6 months with a 5-alpha-reductase inhibitor without significant side effects) **OR** is patient unable to tolerate medical therapy? (**Please submit records supporting failed medical therapy**) Y_____ N_____<br>c. Is Prostate gland volume estimated to be ≤80 cc, on ultrasound or other radiological assessment? Y_____ N_____<br>d. Does Prostate anatomy demonstrate normal bladder neck without an obstructive or protruding median lobe? Y____ N____<br>e. Does patient have contact dermatitis nickel allergy? Y_____ N_____ |
| 3. | Has the patient had appropriate testing to exclude diagnosis of prostate cancer? Y_____ N_____ |
| 4. | Date of last prostate screening _____ |
| 5. | Is request being ordered by Physician trained in specialty of Urology? Y_____ N_____ |
| 6. | Name of FDA approved urethral lift device system to be used by a physician trained in the specialty of Urology: _____ |

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## (Page 2)

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PHYSICIAN ATTESTATION: By signing below, I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Please certify the following by signing and dating below:

| Physician signature: | | Date: | |
|---|---|---|---|

Fax this form with the required documentation to the appropriate fax number below:

| **Department** | **Fax Number** | **Department** | **Fax Number** |
|---|---|---|---|
| Discharge Services | 800.228.0838 | Medical Drugs | 800.795.9403 |
| PPA/Case Mgmt/Acute Inpt | 800.571.7942 | ST PPO PPA/UM | 866.225.5258 |
| | 800.672.6587 | ST PPO Transplant | 919.765.1553 |
| | 800.459.1410 | - | - |