HealthPartners®

Prior Authorization for Upper airway hypoglossal nerve stimulation therapy for obstruction sleep apnea

Fax completed forms to **(952)853-8714.** Call Utilization Management (UM) at **(952)883-6333** with questions. Incomplete forms will be returned.
Submit clinical documentation to support your request.

Member information

First Name _____ MI _____ Last Name _____

HealthPartners ID # _____ DOB _____

Requester information

Form completed by: First Name _____ Last Name _____

Your business name _____

Your business street address _____

Your business city _____ Your business state _____ Your business zip _____

Phone* _____ Fax** _____

Ordering provider information

Provider first name _____ Provider last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic city _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Procedural provider information

Provider first name _____ Provider last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic city _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Facility site for procedure or surgery

Facility name _____

Facility street address _____

Facility City _____ Facility state _____ Facility zip _____

Billing tax ID (claim may be rejected if incorrect) _____

Phone* _____ Fax** _____

**Confidential voicemail required*
***For outcome notification*

HealthPartners®

Procedure or surgery

Only include codes requiring prior authorization; other codes will not be addressed

Primary diagnosis code _____ Description _____

Secondary diagnosis code _____ Description _____

Procedure code(s) _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Procedure(s) or surgery description _____

_____

Proposed date of procedure _____ or ☐ TBD

Will waiting the standard review time seriously jeopardize member's health, life or ability to regain maximum functioning? ☐ yes ☐ no

Clinical reason for urgency (not scheduling issues) _____

1. ☐ FDA approved device (i.e. Inspire System Models 3024 and 3028)

2. Age: _____

3. BMI: _____

4. Member has ability or necessary assistance to operate the sleep remote control ☐ Yes ☐ No

5. Member has been evaluated by a Sleep Specialist and completed an in-lab polysomnography (PSG) or validated home sleep test within 24 months of initial consultation for hypoglossal nerve therapy (Medicare requires a PSG, Home sleep test not accepted)
PSG/Home Sleep test Date: _____

6. Results of sleep test:
   a: Apnea hypopnea index (AHI) events per hour _____

   b: Central plus mixed apneas percentage total AHI _____

7. Conservative therapies must include a trial of Continuous Positive Airway Pressure (CPAP) for a minimum of one month which demonstrates:

☐ CPAP failure (defined as AHI greater than 15 despite CPAP usage)

OR

☐ CPAP Intolerance

8. Results of Drug-Induced Sleep endoscopy (DISE) procedure
☐ Demonstrates absence of complete concentric velopharyngeal collapse (soft palate and posterior nasopharyngeal wall)
Procedure Date: _____