blue of california

| Prior Authorization Request Form | Elective Percutaneous Coronary Intervention (PCI) |
|---|---|
| **Standard Fax Number:** 1 (844) 807-8997 | **Urgent Fax Number:** 1 (844) 807-8996 |

**Use AuthAccel - Blue Shield's online authorization system** - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

**Notice: Blue Shield of CA has a 5 Business Day turn-around time on all Standard Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.**

☐ New Standard Request ☐ New Urgent Request ☐ Standing Referral

**Important For Urgent Requests:** Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. ***If there is no MD signature present the request will be processed as a Standard request.***

***MD Signature REQUIRED For Urgent Requests Only:***

☐ **Modification Or** ☐ **Extension Requests Complete the Section Below:**

| Date Last Authorized: | Previous Authorization Number: |
|---|---|
| MD/NP/PA justification for modification or extension: | |

**Patient Information:**

| First Name: | Last Name: |
|---|---|
| Date of Birth: | ID Number: |
| Address: | |

**Referring/Prescribing Provider:**

| Name: | | | NPI: | |
|---|---|---|---|---|
| Street Address + Suite #: | | | | |
| City: | State: | Zip: | Phone: | Fax: |
| Type of Provider: ☐ PCP ☐ Specialist Type: | | | Contact Name and Phone Number: | |

**Servicing/Billing: Provider/Vendor/Lab** *If same as Referring/Prescribing Provider Check Here* ☐

| Name: | Tax ID: | NPI: |
|---|---|---|
| Street Address + Suite #: | | |

| City: | State: | Zip: | Phone: | Fax: |
|---|---|---|---|---|
| Specialist Type: | | | Contact Name and Phone Number: | |

**If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:**

| Group Name: | | NPI: |
|---|---|---|
| Street Address + Suite #: | | |
| City: | State: | Zip: |

**Billing Facility (If Applicable):**

| Facility Name: | | | NPI: | |
|---|---|---|---|---|
| Street Address + Suite #: | | | | |
| City: | State: | Zip: | Phone: | Fax: |
| Contact Name and Phone Number: | | | | |

| **Anticipated Date of Service:** | **If Lab, Draw Date:** |
|---|---|

**Place of Service: (Check One Box Only or If typing replace box with an "X"):**

| | | |
|---|---|---|
| ☐ Office | ☐ Home | ☐ On Campus OP Hosp |
| ☐ Acute Rehab | ☐ Hospice | ☐ PHP |
| ☐ Ambulance- Air or Water | ☐ Independent Clinic | ☐ RTC – Psychiatric |
| ☐ Ambulance-Land | ☐ Independent Laboratory | ☐ RTC – SUD |
| ☐ Ambulatory Surgical Center | ☐ Inpatient Hospital | ☐ Skilled Nursing Facility |
| ☐ Assisted Living Facility | ☐ Intermediate Care Facility | ☐ Telehealth |
| ☐ Birthing Center | ☐ IOP | ☐ Urgent Care Facility |
| ☐ Custodial Care Facility | ☐ IP Psychiatric Facility | ☐ Other - Please Specify: |
| ☐ End Stage Renal Disease Tx | ☐ Nursing Facility | |
| ☐ Group Home | ☐ Off Campus OP Hosp | |

**Please enter all codes requested; unlisted codes must have a description.**
**Please include the quantity for each code requested and if applicable, left, right or bilateral designations.**

ICD-10 Code(s):

CPT/HCPC Code(s):

**For questions: Call BSC Medical Care Solutions Phone Number: 1-800-541-6652**

**Please provide the following documentation:**

- ☐ **History and physical and/or consultation notes including:**
  - ☐ Angina description (Canadian Cardiovascular Society Grading of Angina Pectoris, Class I, II, III or IV) Enter classification:
  - ☐ Documentation of 1 or more severe (greater than or equal to 70% diameter) epicardial (non-left main) artery or intermediate (50 to 69% diameter) left main coronary artery stenosis detected by diagnostic coronary angiography, or with a Fractional Flow Reserve (FFR) using Coronary Computed Tomography Angiography (CCTA) of less than or equal to 0.80
  - ☐ 2017 "Appropriate Use Criteria for Coronary Revascularization" (AUC) score documented by the requesting physician
  - ☐ If the AUC score is 7 - 9 ("appropriate use"), (the cardiologist must document the score and indication in the medical records)
  - ☐ If the AUC score is 4 - 6 ("may be appropriate") or 1 - 3 ("rarely appropriate"), the cardiologist must also include a brief narrative describing the clinical scenario(s) justifying the revascularization procedure. Clinical risk factors which may support the procedure include one or more of the following:
    - ☐ Unusual location of obstruction(s), unusual coronary anatomy, or unusual flow dynamics noted by the cardiologist
    - ☐ Intercurrent cardiac disease (e.g., congestive heart failure, myocardial disease, arrhythmia, valvular disease)
    - ☐ Current or recent smoking history (within one year)
    - ☐ Cardiologist documentation of difficult-to-control uncontrolled hypertension on maximal therapy or uncontrolled dyslipidemia on maximal therapy
    - ☐ Diabetes mellitus with a first or second degree relative with premature coronary artery disease (i.e., age less than 65, MI or coronary intervention)
    - ☐ Strong family history of coronary artery disease
    - ☐ Prior PCI or CABG procedure
  - ☐ Pertinent past procedural and surgical history
  - ☐ Radiology report(s) (i.e., MRI, FFRCT, CCTA)

Visit our website at blueshieldca.com