**PRIOR AUTHORIZATION PRESCRIPTION REQUEST FORM FOR LUMBAR ORTHOSIS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Please Send RX Form & Pertinent Chart Notes** | | | **Fax No: (305) 390 3669** |
|  | **PLEASE SEND THIS FORM BACK IN 3 BUSINESS DAYS** | | |
|  |  |  |  |
| Date: | ${order\_date} |  |  |
| First: ${fname} | Last: ${lname} | Physician Name: ${phy\_name} | |
| DOB: | ${dob} | NPI: | ${phy\_npi} |
| Address: | ${address} | Address: | ${phy\_address} |
| City: | ${city} | City: | ${phy\_city} |
| State: | ${state} | State: | ${phy\_state} |
| Postal Code: | ${postal\_code} | Postal code: | ${phy\_postal\_code} |
| Patient Phone Number: ${phone\_num} | | Phone Number: ${phy\_phone\_num} | |
| Primary Ins: ${primary\_ins} | Policy #: ${policy\_num} | Fax Number: | ${phy\_fax} |
| Private Ins: ${private\_ins} | Policy #: - |  |  |
| Height: ${height} | Weight: ${weight} |  |  |
|  |  |  |  |

*This patient is being treated under a comprehensive plan of care for back pain.*

*I, the undersigned; certify that the prescribed orthosis is medically necessary for the patient’s overall well-being. This patient has suffered an injury or undergone surgery. In my opinion, the following back orthosis products are both reasonable and necessary in reference to treatment of the patient’s condition and/or rehabilitation. My patient has been in my care regarding the diagnosis below. This is the treatment I see fit for this patient at this time. I certify that this information is true and correct.*

**DIAGNOSIS:** Provider can simply cut off the diagnosis which they don’t find appropriate

Lumbar/ Lumbosacral Intervertebral Disc Degeneration (M51.36)

Other intervertebral disc degeneration, lumbosacral region (M51.37)

Spinal Stenosis,lumbar region(M48.06)

Spinal stenosis, lumbosacral region (M48.07)

Other intervertebral disc disorders, lumbosacral region (M51.87)

Low back pain (M54.5)

Unspecified osteoarthritis, unspecified site (M19.90)

Other/Explain (Include Code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Our evaluation of the above patient has determined that providing the following back pain orthosis product will benefit this patient:***

**DISPENSE:**

L0651: LUMBAR-SACRAL ORTHOSIS (LSO), SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF

Length of need is 99 months unless otherwise specified: \_\_\_\_\_ 6 - 99 (99= LIFETIME)

${phy\_signature:100:80} ${phy\_signed\_date:}

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Name:** ${phy\_name} **NPI:** ${phy\_npi}