

**REQUEST FOR PRIOR AUTHORIZATION**

Patient Name: \_\_\_\_\_

Insurance ID: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Name of Hospital/Facility: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Procedure will be performed:

Inpatient: Anticipated stay: \_\_\_\_\_ Day(s)

Outpatient:

Diagnoses:

Idiopathic Gastroparesis (536.3) or  Diabetic Gastroparesis (250.6X + 536.3)

CPT Procedure Codes: \_\_\_\_\_

\_\_\_\_\_

Current symptoms: \_\_\_\_\_

\_\_\_\_\_

Objective evidence confirming diagnosis and current symptoms:

Date of last Gastric Emptying Test (GET): \_\_\_\_\_

Result of GET: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

History of Weight loss:

Date: \_\_\_\_\_ Weight: \_\_\_\_\_

Date: \_\_\_\_\_ Weight: \_\_\_\_\_

Date: \_\_\_\_\_ Weight: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How many days has patient spent in the hospital in the past year due to Gastroparesis? \_\_\_\_\_

Most recent hospitalization was for how many days? \_\_\_\_\_

Supplemental Nutrition:

J-Tube: Since \_\_\_\_\_

TPN: Since \_\_\_\_\_

Other: \_\_\_\_\_ Since \_\_\_\_\_

Nausea and Vomiting:

Frequency of Nausea per week: \_\_\_\_\_

Frequency of Vomiting per week: \_\_\_\_\_

Medication History:

The patient has tried, without success, the following medications:

<u>Medication</u>	<u>Outcome</u>
<input type="checkbox"/> Cisapride	_____
<input type="checkbox"/> Compazine	_____
<input type="checkbox"/> Domperidone	_____
<input type="checkbox"/> Erythromycin	_____
<input type="checkbox"/> Metoclopramide	_____
<input type="checkbox"/> Phenergan	_____
<input type="checkbox"/> Reglan	_____
<input type="checkbox"/> Tigan	_____
<input type="checkbox"/> Zelnorm	_____
<input type="checkbox"/> Zofran	_____
<input type="checkbox"/> Other	_____

Current Medical Regimen:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Medical Complications Resulting From the Diagnosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_