SecurityHealth Plan℠
Promises kept, plain and simple.®

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Blepharoplasty, Blepharoptosis Repair

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

Is this for congenital ptosis (colored frontal photographs and automated visual fields must be submitted at the time of prior authorization request). . . . . ☐ Yes ☐ No

- Infant or child has congenital ptosis. . . . . ☐ Yes ☐ No
- Ptosis interferes with field of vision. . . . . ☐ Yes ☐ No
- Child has abnormal head posture.. . . . . ☐ Yes ☐ No

Is this for upper eyelid blepharoplasty (colored frontal photographs and automated visual fields must be submitted at the time of prior authorization request) . . . . . ☐ Yes ☐ No

- Does member have any of these symptoms or findings: ☐ ☐
  - Prosthesis difficulties in an anophthalmia socket; defects predisposing to corneal or conjunctival irritation . . . . . ☐ Yes ☐ No
  - Painful symptoms of blepharospasm refractory to medical management; treat peri-orbital sequelae of thyroid disease and nerve palsy, and periorbital; sequelae of other nerve palsy (e.g. exposure keratitis) . . . . . ☐ Yes ☐ No
  - Upper eyelid defect caused by trauma, tumor, or ablative surgery resulting in a severe physical deformity or disfigurement which is causing functional visual impairment . . . . . ☐ Yes ☐ No
- Clinically significant impairment of upper/outer visual fields caused by redundant skin weighing down lashes of the upper eyelid resulting in any one of the following: Difficulty reading due to upper eyelid drooping; looking through the eyelashes; seeing the upper eyelid skin. . . . . ☐ Yes ☐ No

Is this for lower eyelid blepharoplasty (colored frontal photographs and automated visual fields must be submitted at the time of prior authorization request) . . . . . ☐ Yes ☐ No

Does member have any of these symptoms or findings:

- Proper positioning of prescription eyeglasses is precluded ***and*** is secondary to ***any*** of the following conditions in association with functional visual impairment: Chronic systemic corticosteroid therapy; dermatomyositis; Graves' disease; myxedema; nephrotic syndrome; polymyositis; scleroderma; Sjögren's syndrome; systemic lupus erythematosus; facial nerve damage . . . . . ☐ Yes ☐ No

- Is there functional visual impairment (documented uncontrolled tearing or irritation) and failed conservative treatments ☐ Yes ☐ No

Is this for blepharoptosis (ptosis) repair (colored straight ahead photographs must be submitted at the time of prior authorization request) ☐ Yes ☐ No

Does member have any of these symptoms or findings:

- Documented complaints of interference with vision or visual field-related activities, such as difficulty reading or driving due to eyelid position ☐ Yes ☐ No
- Other causes of ptosis are ruled out (e.g. recent botox injections, myasthenia gravis when applicable) ☐ Yes ☐ No
- Documentation of a visual field test without the eyelid or brow taped showing points of visual loss inside the twenty-five degree circle of the superior field that is corrected when taped and shows improvement in the superior field with no visual loss inside the forty degree circle of the superior field ☐ Yes ☐ No

Is this for brow ptosis repair (brow lift) (colored frontal photographs and automated visual fields must be submitted at the time of prior authorization request) ☐ Yes ☐ No

Does member have any of these symptoms or findings:

- Brow ptosis is causing a functional impairment of upper/outer visual fields with documented interference with vision or visual field related activities such as difficulty reading due to upper eyelid drooping, looking through the eyelashes, or seeing the upper eyelid skin ☐ Yes ☐ No
- Documentation that includes that the other causes have been eliminated as the primary cause for the visual field obstruction (e.g. Botox® treatments within the past 6 months) ☐ Yes ☐ No

Is this for extended blepharospasm ☐ Yes ☐ No

Does member have any of these symptoms or findings:

- Debilitating symptoms (e.g., pain) ☐ Yes ☐ No
- Conservative treatment has been tried and failed, or is contraindicated (e.g., Botox®) ☐ Yes ☐ No

Is this for eyelid ectropion or entoprion repair (colored frontal photographs must be submitted at the time of prior authorization request) ☐ Yes ☐ No

Ectropion ☐ Yes ☐ No

Does member have any of these symptoms or findings:

- Pain or discomfort, excess tearing, exposure keratitis; keratoconjunctivitis; or corneal ulcer ☐ Yes ☐ No

Entropion (eyelid turned inward) ☐ Yes ☐ No

Does member have any of these symptoms or findings:

- Pain or discomfort, excess tearing, trichiasis; or irritation of cornea or conjunctiva ☐ Yes ☐ No
- Conservative treatments have been tried and failed ☐ Yes ☐ No

Is this for eyelid surgery with an anophthalmic socket ☐ Yes ☐ No

Does member have any of these symptoms or findings:

- Patient has an anophthalmic condition ☐ Yes ☐ No
- Patient is experiencing difficulties fitting or wearing an ocular prosthesis ☐ Yes ☐ No

Is this for upper eyelid tightening (colored frontal photographs must be submitted at the time of prior authorization request) ☐ Yes ☐ No

Does member have any of these symptoms or finding(s):

- Functional impairment ☐ Yes ☐ No
- Conservative treatments have been tried and failed ☐ Yes ☐ No
- Simple repair of ectropion or entropion will not correct condition ☐ Yes ☐ No
- Epiphora (excess tearing) not resolved by conservative measures; corneal dryness unresponsive to lubricants; or corneal ulcer ☐ Yes ☐ No

Is this for surgical correction of upper and lower eyelid retraction (colored frontal photographs and automated visual fields must be submitted at the time of prior authorization request) ☐ Yes ☐ No

Does the member having any of these findings:

1. There is functional impairment (e.g., dry eyes, pain/discomfort, tearing, blurred vision) ☐ Yes ☐ No
2. Thyroid eye disease, two or more Hertel measurements at least 6 months yes no apart with the same base measurements are unchanged ☐ Yes ☐ No
3. Tried and failed conservative treatments ☐ Yes ☐ No

Is this for repair of floppy eyelid syndrome (colored frontal photographs and automated visual fields must be submitted at the time of prior authorization request) ☐ Yes ☐ No

1. Subjective symptoms must include eyelids spontaneously "flipping over" when they sleep due to rubbing on the pillow and one of the following: Eye pain or discomfort; excess tearing; or eye irritation, ocular redness and discharge ☐ Yes ☐ No
2. Does the member have any of these findings: Eyelash ptosis; significant upper eyelid laxity; presence of giant papillary conjunctivitis; superficial punctate erosions (SPK); corneal abrasion; or microbial keratitis ☐ Yes ☐ No
3. Documentation that conservative treatment has been tried and failed ☐ Yes ☐ No

Is this for repair of paralytic lagophthalmos treatments ☐ Yes ☐ No

Does the member have any of these findings:

1. Members are expected to have delayed, incomplete recovery of facial nerve function ☐ Yes ☐ No
2. Have exposed cornea and inadequate lacrimation ☐ Yes ☐ No
3. Have failed conservative treatment (e.g., corneal lubricants, moisture chambers, or taping of lower eyelid). ☐ Yes ☐ No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:
Security Health Plan
Health Services Department
PO Box 8000
Marshfield, WI 54449-8000
Fax 715.221.6616

Marshfield Clinic providers route to:
Health Services Department
Routing location, SHP

If you have any questions, please contact Customer Service at 1.800.472.2363.

