Prior authorization checklist for Cervical Dystonia patients

First name _____ **Middle** _____ **Last name** _____ **DOB** _____

Diagnosis of Cervical Dystonia (*check one*)

☐ **G24.3** - Spasmodic Torticollis	☐ Other:

Procedure Code (*check one*)

☐ **64616**	☐ Other:

Modifier (*check if applicable*)

☐ 50 ☐ LT ☐ RT ☐ Other:

Guidance Code (*check if applicable*)

☐ **95873** ☐ **95874** ☐ Other:

Head Posturing

☐ Torticollis ☐ Laterocollis ☐ Anterocollis ☐ Retrocollis

☐ Sagittal Shift ☐ Lateral Shift

History of Symptoms

Date when symptoms began _____

☐ History of recurrent clonic or tonic involuntary contractions of one or more of the following muscles: sternocleidomastoid, trapezius, levator scapulae, scalene or posterior cervical muscles (eg, splenius, semispinalis, and longissimus)

☐ Sustained head tilt or abnormal posturing with limited range of motion in the neck

☐ Neck Pain Intensity: ☐ Mild ☐ Moderate ☐ Severe

Expected re-treatment date _____

Subsequent Treatment

☐ There is a response to initial treatment

☐ The individual still meets the medically necessary criteria checked above

Medication History

Drug name:	Class:	Duration:	Outcome:
Drug name:	Class:	Duration:	Outcome:
Drug name:	Class:	Duration:	Outcome:

Other Clinical Assessments (eg, Alternative causes of the member's symptoms have been considered and ruled out, other treatment modalities)

Physician signature: _____ Date: _____

Note: This form provides information commonly used by payer plans to determine prior authorization. It is intended for reference only and does not guarantee approval. Please be sure to check payer policies for the most up-to-date information.

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