

INITIATION OF THERAPY (Use this section for NEW requests- Skip to Continuation for follow-up injections.)

Duration of symptoms: _____

Average pain level on a scale of 0 (zero pain) to ten (10) (extreme pain): _____

Conservative treatment:

- **Activity Modification** (please describe activity and dates of treatment)

Activity: _____

Activity Dates: _____

- **NSAIDS /Pain Medication** (what medication(s) and treatment dates):

Medication(s): _____

Date(s): _____

- **Physical Therapy (PT)** - (please note dates of PT or if contraindicated, why):

Dates PT completed: _____

- **IF NOT APPLICABLE PLEASE EXPLAIN HERE:** _____

Response to diagnostic block(s):

- What percent (%) of symptom or pain relief achieved (using visual analog scale or verbal descriptor scale) within one (1) hour using short acting local anesthetic or two (2) hours with longer-acting anesthetic: _____%

CONTINUATION OF THERAPY (Request for authorization of follow-up injections)

Response to diagnostic block(s):

- What percent (%) of symptom or pain relief achieved (using visual analog scale or verbal descriptor scale) within one (1) hour using short acting local anesthetic or two (2) hours with longer-acting anesthetic: _____%

Please complete (include latest available clinical notes) and fax with your prior authorization request toll free (888) 802-5711.

If you have questions please call (505) 342-4660 extension 180783.