Facet Joint Injections

Marketplace

(866) 472-4575 – Toll Free Fax

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 to (866) 472-4575.