Epidural Steroid Injection

Centennial Care

(888) 802-5711 – Toll Free Fax

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

Is there a documented cervical or lumbar nerve root compression/radiculopathy confirmed by CT, MRI or nerve conduction velocity testing? (please circle) **YES** **NO**

Conservative treatment (If this is not feasible, please explain why below):

- **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:** _____

  _____

  _____

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

Response to diagnostic phase or previous injection

Diagnostic Phase: A total of two (2) injections for diagnosis may be given no less than one (1) week apart, preferably two (2) weeks apart. Please note percent (%) symptom or pain relief (using visual analog scale or verbal descriptor scale) and how long this relief lasted.

- Date of last injection: _____
- Percent (%) pain or symptom relief:_____%
- How long did pain or symptom relief last from the date of the last injection? _____

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