Prior Approval Request: Abdominal Panniculectomy (354N)

To request that abdominal panniculectomy be insured, this form must be **completed in full by the specialist performing the procedure**.
Email completed forms and photos to prss@health.gov.sk.ca or mail to:
Medical Services (PRSS), 2nd floor, 3475 Albert Street, Regina, SK S4S 6X6

Once the request has been reviewed, the Ministry's decision will be sent to you in writing. It is your responsibility to discuss the outcome with your patient.

PATIENT INFORMATION

Last Name	First Name	DOB	Health Services Number
		DD MM YYYY	

APPLYING SASKATCHEWAN SPECIALIST

Please note: Only the specialist **who will be performing surgery** can complete this form requesting coverage**.**

Last Name	First Name	MSB Billing Number	Fax	Phone

ELIGIBILITY

As outlined in Section N of the Physician Payment Schedule, **all the following four (4) criteria must be met** for an abdominal panniculectomy to be insured:

1) Patient has experienced weight loss with a previous Body Mass Index (BMI) greater than 40; **AND**
2) Patient has a current BMI of 30 or less; **AND**
3) Patient has maintained this weight for a period of no less than twelve (12) months; **AND**
4) Patient has **chronic and recurrent skin condition** (cellulitis, skin necrosis, ulcers under the pannus) which has failed to respond to (or be medically managed by) conservative medical treatment for 6 months of medically supervised therapy.

MEDICAL INFORMATION

The following are not indications for abdominal panniculectomy: back pain, multiple gestation, previous cesarean section, tethered abdominal scars, postural changes, or rectus diastasis

Patient's Height: _____ft/in _____cm

Patient's Weight: previous _____ lbs. _____ kg current _____ lbs. _____ kg

Patient's BMI: previous _____ current _____

Length of time patient has maintained current weight: _____

To confirm presence of applicable **skin conditions** that have failed to respond to, or be managed by, hygiene practices and medical treatment for at least **six (6) months** of medically supervised therapy you **must provide** physician visit notes which clearly indicate the nature of the skin condition, treatments attempted, and the response to treatment.

All requests must include:
Good quality colour photographs (front and lateral) which show a clear image of at least one of the associated skin conditions: i.e., cellulitis, skin necrosis, skin ulceration and/or open areas withing skin folds.

DECLARATION

I declare, as the Saskatchewan Specialist, the information provided on this form is true and correct to the best of my knowledge. I hereby request to perform and submit for payment 354N for the above beneficiary.

Attachment Checklist: ☐ clinical notes ☐ good quality colour photographs

Signature: _____ Date: _____