**PRIOR APPROVAL REQUEST**

**Adult Epidural & Therapeutic Nerve Root Blocks for**

**Lumbar or Sacral Radiculopathy**

Hertfordshire and west Essex Evidence Based Intervention policies can be viewed at  
<https://www.hweclinicalguidance.nhs.uk/clinical-policies>

**Please complete and return this form along with clinic letter/supporting evidence to**:

priorapproval.hweicb@nhs.net Tel: 01707 685354

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| Patient consent | This application has been discussed with the patient and the patient consents to relevant information being shared with the ICB | Please tick |

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| Date form completed |  |
| Patient Name |  |
| Patient DOB |  |
| NHS Number |  |
| Hospital Number |  |
| Patient’s GP and practice |  |

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| Applying clinician’s name |  |
| Job title |  |
| Contact details (including email) |  |
| Declaration | I declare that the information provided is, to the best of my knowledge, true and I am aware that this procedure may be subject to clinical audit. |

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| **Patient measurements – Must be completed for all applications** |
| Height: ………. cm Weight: ………… kg BMI …..……. kg/m²  Date measured……………………….. |

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| **Exact site of**  **proposed injection** | **Funded injection sites include interlaminar, transforaminal and caudal epidurals and nerve root injections see policy for further details.** |

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| **First Time Epidural or Therapeutic Nerve Root Injection** | |
| **The ICB will not routinely fund epidural injections for patients with non-specific low back pain.**  **The ICB will fund epidural injections of local anaesthetic and steroid, providing ALL of the criteria below have been met:** | **Tick** |
| Confirmation that you are NOT applying for an epidural injection for a patient with non- specific low back pain. |  |
| Confirmation that your patient does NOT have neurogenic claudication with a diagnosis of central canal spinal stenosis. |  |
| The patient is 16 years or older. |  |
| The patient has radicular pain consistent with the level of spinal involvement. |  |
| The pain is having a significant impact upon the patient’s ADLs (see below). |  |
| The pain persists despite non-invasive management as per local pathways and the national back pain pathway (advice on self-management, analgesia, exercise programme +/- manual therapy +/- psychological therapy OR low intensity combined physical and psychological programme) UNLESS an MDT agrees that there is acute severe radiculopathy in which case this criterion may be waived (see below). |  |
| Patients must have actively participated in the decisions in respect of their treatment and demonstrated commitment to their long-term treatment plan. |  |

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| **Type of pain** | **Tick** |  | **Type of pain** | **Tick** |
| The pain is due to prolapsed intervertebral disk  **AND** the pain is acute (<3 months) at the time of referral  **AND** the pain is severe and uncontrollable (rated at 7/10 or more on the visual analogue pain scale). |  | **OR** | The pain is due to inflammatory or compressive causes  **AND** the pain is moderate (5/10 or more on visual analogue pain scale) or severe  **AND t**he pain has lasted more than 6 months  **AND** the aim is to avoid surgery (reflecting patient and clinician choice) or surgery is contraindicated or not feasible. |  |

**Any other type of pain will require an Exceptional Case Request Form**

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| **Effect on ADLs** |  |

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| **Non-invasive management**  **Details must be provided** | **Treatment** | **Yes / No** | **Dates/Type/Dose/Duration/Comments** |
| Advice on self-management |  |  |
| Analgesia |  |  |
| Exercise programme |  |  |
| Manual therapy |  |  |
| Psychological therapy |  |  |
| Other |  |  |

**If an MDT agrees that there is acute severe radiculopathy in which case non-invasive management may be waived; this must be evidenced in the clinic letter.**

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| , **Repeat Epidural or Therapeutic Nerve Root Injection** | |
| **Repeat epidural injections or nerve root injections will be routinely funded when ALL the following criteria have been met:** | **Tick** |
| The criteria for epidurals set out above have been met. |  |
| 6 months of benefit and functional improvement was achieved following the previous injection.  Date of previous injection \_\_/\_\_/\_\_\_ |  |
| **Patients must show commitment to taking responsibility for managing their condition by demonstrating relevant lifestyle changes which include:** | |
| Weight loss. |  |
| Increased physical fitness through exercise and physiotherapy.  Date physiotherapy completed \_\_/\_\_/\_\_\_ |  |
| Engaging with activities to promote mental wellbeing and any treatment plans for mental health problems. Details must be provided in the clinic letter. |  |
| Others such as: diet control, avoidance of illicit drugs and alcohol, improvement in sleep hygiene, improved engagement in activities of daily living and purposeful occupation where appropriate (or not able to participate in such activities). Details must be provided in the clinic letter. |  |

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| **For patients where the criteria are not met and it can be demonstrated that there is an exceptional healthcare need, an Exceptional Case Request Form can be submitted to the IFR team.** |

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| **Shared decision making** | Patients should be supported with their decisions. Resources that can support implementation of shared decision making can be found on the NHS England website:  <https://www.england.nhs.uk/shared-decision-making/guidance-and-resources/> |