**PRIOR APPROVAL REQUEST**

**Injections and Radiofrequency Denervation**

**for non-specific low back pain**

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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| Specify exact site of injection or RFD |  |
| Patient’sMeasurements | Height…………….cm Weight……………..kg BMI…………….. kg/m²  |

**Please provide details of conservative treatments tried**

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| **Diagnostic Medial Branch Block** |
| **Diagnostic medial branch block will only be commissioned when ALL the criteria below are met** | **Tick** |
| Confirmation that the patient has not had a previous MBB at the same site |  |
| The procedure is intended as a diagnostic test to localise the source of lower back pain to assess suitability for radiofrequency denervation |  |
| The patient is 16 years or older |  |
| The pain has lasted for more than 12 months duration |  |
| The main source of pain is thought to be from structures supplied by the medial branch nerve (i.e. arising from one or more facet joints)  |  |
| The patient has moderate or severe levels of localised back pain (rated as 5/10 or more on a visual analogue scale, or equivalent) at the time of referral |  |
| There has been a failure of non-invasive management as per local pathways and the national back pain pathway.* Guided self-management, exercise programme +/- manual therapy +/- psychological therapies
* Low intensity combined physical and psychological programme (CPPP)
* Comprehensive CPPP or standard pain management programme (PMP)
 |  |
| The patient has been reviewed by a specialist clinician/physiotherapist trained in spinal assessment and this treatment is considered necessary to enable full participation with a rehabilitation programme. |  |
| Where available, the patient agrees to participate in multidisciplinary rehabilitation post ablation in increase likelihood of sustained benefit. |  |

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| **Repeat Diagnostic Medial Branch Block** |
| Repeat **diagnostic** medial branch block at a **new** site will be considered where the criteria above are met.Repeat medial branch block at the **same** site are not routinely commissioned**.**In the unusual circumstance that a repeat diagnostic medial branch block is thought to be necessary due to diagnostic uncertainty, an individual funding request (IFR) should be submitted. Some patients may experience a prolonged response to medial branch blockade such that further interventional treatment is no longer required. However, a prolonged initial response is not an indication for further, therapeutic, medial branch block if the pain returns. |

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| **Has the patient previously had a therapeutic medial branch block (despite not** **being routinely commissioned), and now requires a diagnostic medial branch** **block at the same site?** |  **Tick** |

**If so,**

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| When did this take place? |  |
| Where did this take place? (Hospital/clinic name) |  |

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| **Applications for Radiofrequency Denervation** |
| **Radiofrequency denervation will be commissioned when ALL of the following criteria have been met:** | **Tick** |
| All the above diagnostic medial branch block criteria have been met |  |
| There has been a positive response to a diagnostic medial branch block" to "There has beena positive response to a diagnostic medial branch block (defined as an improvement of 50% in the first 6 hours, ideally should be through diary exercises) to a diagnostic medial branchblock with 1 ml or less of local anaesthetic at each level (No steroids). |  |
| The patient has been referred after assessment by a specialist orthopaedic or MSK service. |  |
| **Radiofrequency denervation will not be funded for patients who have radicular pain without low back pain.** |

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| **Repeat Denervation** |
| Repeat denervation at a **new** site will be considered where the criteria above and in the national EBI programme are met. |
| Repeat denervation at the **same** site is not routinely funded and will only be considered on an individual basis; an IFR is required. |

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| **Diagnostic sacroiliac joint injection**  |
|  | **Tick** |
| This is a diagnostic injection |  |
| Pain is believed to arise from sacroiliac joint |  |
| Local anaesthetic only will be used |  |

Please note that the ICB will **not** fund any other spinal injections for patients with non-specific back pain. This includes epidurals and facet joint injections. In the rare circumstance that a patient meets the guidance criteria for radiofrequency denervation, but the procedure is contraindicated (e.g., presence of pacemaker/ICD/ complex spinal anatomy/ presence of spinal metal work), and the clinician recommends facet joint injections, an individual funding request should be submitted.

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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/> |