Prior Authorization for Transplant

Payer/Plan Name: Case Manager Name: Payer/Plan Phone: Payer/Plan Fax:	☐ **Urgent Request** Please only check this option if the provider believes that waiting for a decision could place the patient's life or health in danger.

Please attach pertinent supporting documentation to facilitate your request, for example, the history & physical, test results, letter of medical necessity, etc.

Prior Authorization Request Form for Transplant

PATIENT INFORMATION

Patient Name:	**DOB:**	**Member ID:**	**Group ID:**

Patient Address, City, State, Zip:

PROCEDURE INFORMATION:

☐ Search & Evaluation Only	**Transplant Type:**	☐ Autologous ☐ Cord Blood	☐ Allogeneic-Matched Unrelated ☐ Allogeneic Related	☐ Donor Leukocyte Infusion (DLI) ☐ Other

ICD-9 Code(s):	**CPT-Code(s):**
Brief Medical History (staging, underlying condition, previous remission, response to other therapies, co-morbidities):	**Rationale for Procedure:**

Is treatment part of a protocol? ☐ **Yes** ☐ **No** **NCT #**_____ **or N/A** ☐
If yes, please explain.

Date of Procedure:	**Date of Arrival for Pre-Transplant Treatment:**
Requesting Provider:	**Provider NPI:**

Requesting Provider's Signature:

Facility:	**Facility Tax ID:**	**Facility NPI**:
Office Contact Name:	**Office Contact Phone:**	
Office Contact Fax:		

The development of this form was sponsored by the National Marrow Donor Program. For free electronic copies or to provide feedback, please visit the Reimbursement Resource Center. V2.2018