TRANSPLANT PRIOR AUTHORIZATION & NOTIFICATION
Organ and Bone Marrow / Stem Cell

Medica requires that providers obtain prior authorization before rendering services. If any items on the Medica Prior Authorization list are submitted for payment without obtaining a prior authorization, the related claim or claims will be denied as provider liability. The provider will have 60 days from the date of the claim denial to appeal and supply supporting documentation required to determine medical necessity.

AUTHORIZATION / NOTIFICATION FOR:			
Step 1:	❑ Evaluation **Scheduled Date:** Complete before scheduling a transplant candidate for a transplant evaluation.	**Step 2:**	❑ Organ Listing ❑ Bone Marrow / Stem Cell **Scheduled Date:** ❑ Standard ❑ Expedited. If so, why?

PART 1 COMPLETE THIS SECTION FOR STEP 1 AND STEP 2 (UPDATE AS NEEDED).

MEMBER		
Member Name:		
Date of Birth:	Member ID Number:	
Member Phone Number:	Medicare Number (if applicable):	
Secondary Insurance Provider / Number:		
PERSON COMPLETING FORM		
Completed By:	Clinic / Facility:	
Fax Number (for reply):	Phone Number:	
TRANSPLANT PHYSICIAN / SURGEON		
Last Name:	First Name:	
Tax ID Number:	Phone Number:	Fax Number:
TRANSPLANT FACILITY		
Name:	Tax ID Number:	
City:	State:	
Phone Number:	Fax Number:	
TRANSPLANT COORDINATION CONTACT		
Financial Coordinator	**Transplant Coordinator**	**Referring Physician**
Name:	Name:	Name:
Phone Number:	Phone Number:	Phone Number:
Fax Number:	Fax Number:	Fax Number:
TRANSPLANT INFORMATION: Organ		
Transplant Indication Diagnosis:		ICD10:
Procedure (CPT):		Code Description:
Organ Type:		Donor Type: ❑ Living ❑ Deceased
Is the patient currently inpatient at the transplant facility? ❑ Yes, Admit Date: ___ / ___ / ___ ❑ No		
FOR **LUNG** TRANSPLANT	❑ Single ❑ Double	
FOR **HEART** TRANSPLANT	❑ ECMO In Place, Date: ___ / ___ / ___	❑ VAD In Place, Date: ___ / ___ / ___ Type:
FOR **KIDNEY** TRANSPLANT (Attach CMS #2728 form)	❑ Dialysis, Start Date: ___ / ___ / ___ ❑ No Dialysis	Peritoneal / Hemodialysis:

TRANSPLANT INFORMATION: Bone Marrow / Peripheral Stem Cell or Other Blood Cell	
Transplant Indication Diagnosis:	ICD10:
Procedure (CPT):	Code Description:
Do you plan or have you done a NMDP donor search? ❑ Yes, Date of Search: ___ / ___ / ___ ❑ No	

TYPE		CELL SOURCE	DONOR	MATCH	INTENSITY TO BE USED
❑ Autologous	❑ Inpatient ❑ Outpatient	❑ Bone Marrow ❑ Peripheral Stem Cell			❑ Myeloablative ❑ Non-myeloablative
❑ Allogeneic		❑ Bone Marrow ❑ Peripheral Stem Cell	❑ Related ❑ Unrelated	❑ HLA Identical ❑ Haploidentical	❑ Myeloablative ❑ Non-myeloablative
❑ Umbilical Cord Blood		❑ Cord Blood	Indicate reason alternative cell source was not selected:		❑ Myeloablative ❑ Non-myeloablative

PART 2 COMPLETE THIS SECTION FOR STEP 2 WHEN PATIENT IS DEEMED A TRANSPLANT CANDIDATE.

Transplant services will be administered within context of an investigational, experimental or research protocol/clinical trial?
❑ Yes ❑ No

If you answered Yes, please provide the following information.	
Clinical Trial Number:	Study's Sponsor:
Use actual clinical trial number assigned. If there's an IDE #, please append it to the clinical trial number. Attach copy of protocol(s).	

Investigational and/or (non-FDA approved) technology, device(s), services or treatments (non- routine care) will be utilized?
❑ Yes ❑ No

If you answered Yes, please provide the following information.
Indicate if you will be billing modifier(s), procedure code(s) or other Clinical Trial Identifiers to indicate those investigational technology, device(s), service(s) or treatments(s):

CLINICAL INFORMATION: Include all documentation (exam/test results) and attach to form submission.

	Questions	Details of Response
PSYCHOSOCIAL Please attach copy of complete Psychosocial Evaluation.	All formal assessments to identify psychosocial risk factors completed, their severity reviewed and documented in the chart. ❑ Yes ❑ No	If Yes, Date: ___ / ___ / ___ If No, attach plan for completion.
	Has the referring physician been contacted and agreed to having the transplant expertise needed to provide care coordination after transplant? ❑ Yes ❑ No	If Yes, provide physician name who is providing care and coordination after transplant: If No, attach plan for care and coordination after transplant (include physician name).
	Does the patient have any unresolved psychosocial concerns? ❑ Yes ❑ No	If Yes, are the concerns being addressed? ❑ Yes, please attach explanation of treatment interventions. ❑ No
	Are the patient/guardian and family support system able to comply with the treatment regimen and necessary follow up? ❑ Yes ❑ No	
	Are the patient's spiritual beliefs related to illness and treatment documented in the chart? ❑ Yes ❑ No	If No, how are the spiritual beliefs being addressed?
	Has inadequate funding to pay for immunosuppressive medications post-transplant been addressed and resolved? ❑ Yes ❑ No	

CLINICAL INFORMATION: Include all documentation (exam/test results) and attach to form submission.		
	Questions	Details of Response
HEALTH CARE DIRECTIVES	Does patient have current advanced health care directives completed, signed and in place? ❑ Yes ❑ No	If Yes, Signed Date: ___ / ___ / ___ If No, attach plan for completion. Date: ___ / ___ / ___
	Is the patient's family/social support system and their involvement in care and decision making documented in the chart? ❑ Yes ❑ No	If No, how is the support system involvement being addressed?
MEDICAL COMPLIANCE	Has the patient had documented non-compliance with medical treatment within the past 6 consecutive months? ❑ Yes ❑ No	If Yes, are the concerns being addressed? ❑ Yes, please attach explanation of treatment interventions. ❑ No
SUBSTANCE OR ALCOHOL USE	Has the patient had active alcohol, tobacco, nicotine delivery system or substance abuse within the past 6 consecutive months? ❑ Yes ❑ No	If Yes, are the concerns being addressed? ❑ Yes, please attach explanation of treatment interventions. ❑ No
PREVENTIVE SCREENING	All preventive screening has been completed, reviewed and documented in the chart. ❑ Yes ❑ No	If Yes, attach documentation of dates of completion for each screening. If No, attach plan for completion. Anticipated Review Date: ___ / ___ / ___
	Does the patient have history of (last 2-5 years) or active malignancy? ❑ Yes ❑ No	If Yes, are the concerns being addressed? ❑ Yes, please describe your required minimum tumor-free wait protocol: ❑ No
MEDICAL	Transplant team indicates patient meets the facility's transplant criteria. ❑ Yes ❑ No	**Please include facility transplant criteria with submission.**
	All program medical evaluation completed, reviewed and documented surgical clearance in the chart. ❑ Yes ❑ No	If Yes, Signed Date: ___ / ___ / ___ If No, attach plan for completion. Anticipated Review Date: ___ / ___ / ___
	Does the patient have cerebrovascular disease? ❑ Yes ❑ No	If Yes, is the disease well compensated? ❑ Yes ❑ No
	Does the patient have untreated active coronary artery disease? ❑ Yes ❑ No	If Yes, is the disease well compensated? ❑ Yes ❑ No
	Does the patient have advanced ilio-femoral vascular disease? ❑ Yes ❑ No	If Yes, is the disease well compensated? ❑ Yes ❑ No
	Does the patient have advanced liver disease? ❑ Yes ❑ No	If Yes, is the disease well compensated? ❑ Yes ❑ No
	Does the patient have active Hepatitis B or Hepatitis C infection for which they are being treated for? ❑ Yes ❑ No	If Yes, is the infection well compensated? ❑ Yes ❑ No

CLINICAL INFORMATION: Include all documentation (exam/test results) and attach to form submission.		
	Questions	Details of Response
MEDICAL	Please list Karnofsky or Lansky performance scores (required for bone marrow and stem cell transplants only).	Karnofsky: Lansky:
	Does the patient have end-stage pulmonary disease? ❑ Yes ❑ No	
	Is the patient HIV positive? ❑ Yes ❑ No	If Yes, is the infection well compensated? ❑ Yes ❑ No
	What is the patient's BMI? Does this meet your facility's criteria for requested transplant? ❑ Yes ❑ No	If No, are the concerns being addressed? ❑ Yes ❑ No
	Does the patient have a cardiac ejection fraction of < 30%? ❑ Yes ❑ No	If Yes, are the concerns being addressed? ❑ Yes ❑ No
	Does the patient have pulmonary disease that requires supplemental oxygen? ❑ Yes ❑ No	If Yes, are the concerns being addressed? ❑ Yes ❑ No

Please note that written documentation from the medical record supporting the procedure must be submitted for all requests. Failure to do so may result in a delay of the decision.

Submission of this completed form certifies that the information is true and accurate. All fields are required for processing your request. Submit form by:

- **For group numbers that begin with A:**
  Fax to 952-992-2396 or email hpshealthmanagement@medica.com.
- **For group numbers that begin with IFB or B:**
  Fax to 952-992-2836 or ifbhealthmanagement@medica.com.
- **For all other group numbers:**
  Fax to 952-992-3556 or email caremanagement@medica.com.
- **U.S. Mail:**
  Medica Utilization Management and Clinical Appeals
  P.O. Box 9310, CP440
  Minneapolis, MN 55440

For questions, call toll-free 1-800-458-5512.

Medica provides information about facilities ranked as Centers of Excellence for transplant procedures. Visit myoptumhealthcomplexmedical.com/gateway/public/transplants/providers.jsp.

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