MEDICA®

Transplant Prior Authorization and Notification
Organ and Bone Marrow /Stem Cell

Please Fax to: (952)-992-3556 **For questions, call:** 1-800-458-5512 (toll free)
OR email: caremanagement@medica.com

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:	Member ID Number:
Date of Birth:	Member Phone Number:
Secondary Insurance Number and Provider:	Medicare Insurance Number (if applicable):
PERSON COMPLETING FORM	
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 CONTACTS		
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: ❑ Yes ❑ No Start Date: ___/___/___	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	

TRANSPLANT INFORMATION: Bone Marrow/Peripheral Stem Cell or Other Blood Cell

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?	❑ No	❑ **Yes:** Provide Clinical Trial Number: _____ and 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?	❑ No	❑ **Yes:** 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	All formal assessments to identify psychosocial risk factors completed, their severity reviewed & 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 & coordination after transplant: _____ **If NO,** attach plan for care & coordination after transplant (include physician name): _____
	Does the patient have any unresolved psychosocial concerns? ❑ Yes ❑ No	**If YES,** are the concerns being addressed? ❑ Yes ❑ No (**If yes,** please attach explanation of treatment interventions)
	Are the patient/guardian and family support system able to comply with the treatment regimen and necessary follow up? ❑ Yes ❑ No	

Please attach copy of complete Psychosocial Evaluation

CLINICAL INFORMATION: Include all documentation (Continued)		
	QUESTIONS	**DETAILS OF RESPONSE**
PSYCHOSOCIAL	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	
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: ___/___/___
	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 ❑ No (**If yes,** please attach explanation of treatment interventions)
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 ❑ No (**If yes,** please attach explanation of treatment interventions)
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 & include 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 ❑ No **If yes,** describe your required minimum tumor-free wait protocol: _____ _____
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 & include 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

CLINICAL INFORMATION: Include all documentation (Continued)

	QUESTIONS	DETAILS OF RESPONSE
MEDICAL (CONTINUED)	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
	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

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

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