Medica

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

Medica Central Health Plan requires that providers obtain prior authorization before rendering services. If any items on the Medica Central Health Plan Prior Authorization list are submitted for payment without obtaining a prior authorization, the related claim or claims will be denied as provider liability.

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 ID Number:	
Member Name:		
Date of Birth:		
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 inadequate funding to pay for immunosuppressive medications post-transplant been addressed and resolved? ☐ Yes ☐ No	
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
PREVENTIVE SCREENING	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

CLINICAL INFORMATION: Include all documentation (exam/test results) and attach to form submission.		
	Questions	Details of Response
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: _____/ _____ / _____

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.

Submit form by utilizing the options below:

- For Commercial (Fully Insured/Self-Funded) and IFB Members: Fax to 952-992-2836 or E-Mail to ifbhealthmanagement@medica.com
- U.S. Mail to Medica Utilization Management Department, PO Box 9310, CP440, Minneapolis, MN 55440

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

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

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