Transplant Request Form for Commercial and Federal Employee Program Members

Transplant Coordinator Contact

Name: ______________________________

Phone Number: ______________________ Fax Number: ______________________

With each type of transplant, please include medical history and physical and psychosocial evaluations.

Member Information

Member Name: ______________________________

Member ID Number: ______________________ Date of Birth: _____/ _____/ _____

Member Phone Number: ______________________

Diagnosis (including ICD-10 Code):

Procedure code(s):

Facility Information

Facility Name: ______________________________

NPI Number: ______________________ Provider Number: ______________________

Continued on next page

Requesting Provider Information

Requesting Provider: ______________________________

Provider Number: ____________________ NPI Number: ____________________

Phone Number: ____________________ Fax Number: ____________________

Address: ______________________________

City: ____________________ State: ________ ZIP: ____________

Transplant Information

Transplant type: ______________________________

Evaluation date: _____/ _____/ _____ Initial inpatient: ☐ Yes ☐ No

Transplant scheduled: ☐ Yes ☐ No Will transplant be performed: ☐ Inpatient ☐ Outpatient

Committee approval date: _____/ _____/ _____

Stem Cell Transplant

Is the transplant related to a clinical trial? ☐ Yes ☐ No

Tentative infusion/transplant date: _____/ _____/ _____

What is the mobilization date? _____/ _____/ _____

Stem cell type: ☐ Autologous ☐ Allogeneic

What is the harvesting date? _____/ _____/ _____

If allogeneic matched donor, then what is the name of the donor?

Donor Name: ______________________________

What is/are the date(s) for IV ablation/high dose chemotherapy?

IV ablation: _____/ _____/ _____ High dose chemotherapy: _____/ _____/ _____

Comments:

Continued on next page

Liver Transplant

MELD score or PELD score if applicable: ____________________

Does patient have ongoing alcohol, tobacco and/or substance use? ☐ Yes ☐ No

Does patient have a diagnosis of Intrahepatic cholangiocarcinoma, neuroendocrine tumors metastatic to liver, or hepatocellular carcinoma that has extended beyond the liver? ☐ Yes ☐ No

Comments:

Kidney Transplant

Creatinine level: ____________________

Glomerular filtration rate: ____________________

Does patient have a history of cancer? ☐ Yes ☐ No

Does patient have diabetes? ☐ Yes ☐ No

Is the patient on dialysis? ☐ Yes ☐ No

Living or deceased donor? ☐ Living donor ☐ Deceased donor

Comments:

Heart Transplant

What are the indications for cardiac transplant?

Comments:

Continued on next page

Lung and Lobar Lung Transplant

Does patient have end-stage pulmonary disease? ☐ Yes ☐ No

Comments:

Allogeneic Pancreas Transplant

What are the indications for pancreas transplant?

Comments:

Total Artificial Hearts and Implantable Ventricular Assist Device

Is this bridge to transplant? ☐ Yes ☐ No   Is this destination therapy? ☐ Yes ☐ No

What is the New York Heart Association Class? ____________________

Does the patient have ongoing alcohol, tobacco or substance use? ☐ Yes ☐ No

Does the patient have end stage organ damage? ☐ Yes ☐ No

Does the patient have sufficient space in the thoracic and/or abdominal cavity for the device? ☐ Yes ☐ No

By submitting this request, you're confirming that you've provided all clinical information available pertinent to this request, and you're requesting the decision be made based on information provided in your submission.

Please complete this form and submit it as an attachment through one of the following options. Tennessee providers may submit authorization requests at any time in Availity®. Out-of-state providers may submit authorization requests through their provider portal or Cohere®. If you have questions about submitting a prior authorization request, please call **(423) 535-5717, option 2**, or contact your eBusiness Network Manager.

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