PREMERA | BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

PRIOR AUTHORIZATION FORM FOR TRANSPLANT RELATED REQUESTS

☐ **PLEASE EXPEDITE!! Please only check this option if the provider believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy (CMS)**

Transplant Related Prior Authorization Requests Fax: 866-809-1370 Phone: 855-339-8127	**For online requests:** www.premera.com/wa/provider/medicare-advantage/medical/
Requesting Provider	**Primary Care / Personal Physician**
Patient Name **DOB**	**Member / Patient ID Number**
Patient Address, City, State, Zip	

Pre-Transplant service(s):

☐ Consult

☐ Cardiac prescreen testing

☐ HLA typing:

☐ Related Name, DOB of siblings:

☐ Unrelated (Attach mbr/sibling typing results)

☐ Comprehensive transplant evaluation (includes labs not on PA list)

Date scheduled

Name of potential donor

☐ Bone marrow biopsy (Include proc and cytology codes)

Transplant

☐ Transplant

If stem cell, indicate transplant protocol:

☐ Wait list management (one-year date span, includes diagnostics.)

Indicate number of visits needed

☐ Wait list biopsy

Type of transplant being considered:

☐ Liver ☐ Heart ☐ Lung ☐ Kidney

☐ Pancreas ☐ SPK ☐ Autologous SCT

☐ Allogeneic SCT

☐ Other cgbcv

ICD-9/10 Code(s) _____

CPT Code(s) _____

_____

Date of Procedure

Facility

Facility TIN#

Facility NPI#

Post-Transplant service(s)

Date of transplant

Date of last transplant clinic visit

☐ Post visit(s)

☐ Post-transplant biopsy

Date of last biopsy

☐ Request to extend existing auth

Number of visits already used

Other

Comments:

Contact Name ******REQUIRED******

Contact Phone

Contact Fax

Total # of pages faxed, including cover page

***This form must be filled out completely.**

***Chart notes are required and need to be submitted with this request.**

***Incomplete requests will be returned to the requestor.**