Neighborhood Health Plan OF RHODE ISLAND™

Transplant Services
Prior Authorization Form

Please return completed form to the Utilization Management Department at (401)459-6023.
Please refer to Neighborhood's Clinical Medical Policies, which are available on our web site, www.nhpri.org for more detailed information about these benefits, authorization requirements, and coverage criteria.

**ALL FIELDS ARE REQUIRED**

| **Member Information** | | |
|---|---|---|
| Member's Name: | Member's ID #: | Member's DOB: |
| **Referring Provider Information** | | |
| Name: | NPI: | Contact Person & Phone Number: |
| Phone: | Fax: | |
| **Transplant Facility Information** | | **Transplant Coordinator Information** |
| Name: | Phone: | Name: _____ |
| NPI: | Fax: | Phone: _____<br>Email: _____<br>Fax: _____ |

| **CLINICAL INFORMATION** | |
|---|---|
| Diagnosis: | Diagnosis Code(s): |
| Transplant institution's selection criteria has been met: ☐ YES ☐ NO | Date & Type of previous transplant(s): |
| **TRANSPLANT INFORMATION ***If currently inpatient, please document below. *** | |
| Date(s) of Service: | Date of Transplant: |
| If this is related to an existing authorization, please provide the authorization number: | |

**Type of Transplant:**

☐ Heart ☐ Lung ☐ Single ☐ Bilateral
☐ Kidney ☐ Liver
☐ Pancreas ☐ Intestinal/Multi-Visceral
☐ Multi-organ - Please specify: _____
☐ Other - Please specify: _____

Bone Marrow Transplants:
☐ Autologous
☐ Allogeneic
☐ Umbilical Cord Blood

☐ CAR-T
**NOTE:** An Approved Pharmacy Authorization for CAR-T is **required**, please provide the Pharmacy auth #: _____

**SETTING & REQUEST TYPE**

Choose a **TOTAL of ONE**:

| **Outpatient** | | **Inpatient** | |
|---|---|---|---|
| ☐ Evaluation | **OR** | ☐ Evaluation | **IMPORTANT NOTE:** The authorization for the chosen setting will only cover services done in that setting. If an authorization is also needed for the other setting, then a separate authorization is needed for the other setting. **DO NOT submit a single request for both inpatient and outpatient services.** |
| ☐ Listing (Initial/Recertification) | | ☐ Listing | |
| ☐ Transplant Procedure | | ☐ Transplant Procedure | |
| ☐ Post-Transplant Follow-Up | | | |

If INPATIENT chosen above:

Is the member currently inpatient at the transplant facility?

☐ Yes, Admit Date: _____ Is the requested service being done during this admission? ☐ Yes ☐ No

☐ No, Planned Admit Date: _____

*****If member does not receive a transplant while inpatient, and continued follow-up for evaluation or listing is required, a new outpatient transplant prior authorization must be requested upon facility discharge.*****

| CPT/HCPCS Code | Units | CPT/HCPCS Code | Units |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**CLINICAL TRIAL, INVESTIGATIONAL, EXPERIMENTAL TREATMENT DETAILS**

Transplant services will be administered within context of an investigational, experimental or research protocol/clinical trial? ☐ No ☐ 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? ☐ No ☐ Yes – Please specify: _____

**REQUIRED INFORMATION/DOCUMENTATION**

**Consultation/Evaluation**

- All medical & behavioral health diagnoses
- Progress notes including disease progression & current status (acute/ chronic, remission, etc.) **Be sure to include height and weight or BMI.**
- MELD/PELD score (Liver only)

**Initial Listing & Recertification**

- Everything from **Consultation/Evaluation** section
- Prior transplant history
- Behavioral health, social work, psycho-social support network evaluations (initial only)
- Test results
- Dental evaluation
- Multidisciplinary transplant team documentation

**ATTENTION: Requests submitted without sufficient information will encounter delayed processing.**

**Authorization is not a guarantee of payment.**

| **Authorization #:** | **Date(s) of Service:** | ☐ **Not Approved – Letter to Follow** |
|---|---|---|
| **UM Initials:** | **Notification Date:** | |

**Services Approved:**

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