blue CALIFORNIA

Transplant Prior Authorization Form	Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma and POEMS Syndrome
Phone Number Urgent and Standard: 1 (916) 841-1130	Fax Number: 1 (916) 350-8865

Use AuthAccel - Blue Shield's online authorization system - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

Notice: Blue Shield of CA has a 5 Business Day turn-around time on all Standard Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

☐ **New Standard Request** ☐ **New Urgent Request**

Important For Urgent Requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. ***If there is no MD signature present the request will be processed as a Standard request.***

MD Signature REQUIRED For Urgent Requests Only:

☐ **Modification Or** ☐ **Extension Requests Complete the Section Below:**

Date Last Authorized:	Previous Authorization Number:
MD/NP/PA justification for modification or extension:	

Patient Information:

First Name:	Last Name:
Date of Birth:	ID Number:
Address:	

Referring/Prescribing Provider:

Name:	**Billing Tax ID:**	NPI:
Street Address + Suite #:		

City:	State:	Zip:	Phone:	Fax:
Type of Provider: ☐ PCP ☐ Specialist Type:			Contact Name and Phone Number:	

Servicing/Billing: Provider/Vendor/Lab *If same as Referring/Prescribing Provider Check Here* ☐

Name:	**Billing Tax ID:**	NPI:
Street Address + Suite #:		

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City:	State:	Zip:	Phone:	Fax:
Specialist Type:			Contact Name and Phone Number:	

If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:

Group Name:	**Billing Tax ID:**	NPI:
Street Address + Suite #:		
City:	State:	Zip:

Billing Facility (If Applicable):

Facility Name:	**Billing Tax ID:**	NPI:
Street Address + Suite #:		

City:	State:	Zip:	Phone:	Fax:
Contact Name and Phone Number:				

Anticipated Date of Service:	**If Lab, Draw Date:**

Place of Service: (Check One Box Only or If typing replace box with an "X"):

☐ Office	☐ Home	☐ On Campus OP Hosp
☐ Acute Rehab	☐ Hospice	☐ PH
☐ Ambulance- Air or Water	☐ Independent Clinic	☐ RTC – Psychiatric
☐ Ambulance-Land	☐ Independent Laboratory	☐ RTC –SUD
☐ Ambulatory Surgical Center	☐ Inpatient Hospital	☐ Skilled Nursing Facility
☐ Assisted Living Facility	☐ Intermediate Care Facility	☐ Telehealth
☐ Birthing Center	☐ IOP	☐ Urgent Care Facility
☐ Custodial Care Facility	☐ IP Psychiatric Facility	☐ Other - Please Specify:
☐ End Stage Renal Disease Tx	☐ NursingFacility	
☐ Group Home	☐ Off Campus OP Hosp	

Please enter all codes requested; unlisted codes must have a description.
Please include the quantity for each code requested and if applicable, left, right or bilateral designations.

ICD-10 Code(s):

CPT/HCPC Code(s):

For questions: Call BSC Medical Care Solutions Phone Number: 1-(916) 841-1130

Please provide the following documentation:

- ☐ **History and physical and/or consultation notes including:**
  - ☐ Bone marrow transplant consultation report and/or progress notes documenting:
    - ☐ Diagnosis (including disease staging) and prognosis
    - ☐ Synopsis of alternative treatments performed and results
    - ☐ Specific transplant type being requested
  - ☐ Surgical consultation report and/or progress notes
  - ☐ Results of completed transplant evaluation including:
    - ☐ Clinical history including comorbidities
    - ☐ Specific issues identified during the transplant evaluation
    - ☐ Consultation reports/letters (when applicable)
    - ☐ Correspondence from referring providers (when applicable)
    - ☐ Identification of donor for allogeneic related bone marrow/stem cell transplant (when information available)
  - ☐ Medical social service/social worker and/or psychiatric (if issues are noted) evaluations including psychosocial assessment or impression of patient's ability to be an adequate candidate for transplant
  - ☐ Radiology reports including:
    - ☐ Chest x-ray (CXR)
    - ☐ PET scan, CT scan and bone survey (as appropriate)
  - ☐ Cardiology procedures and pulmonary function reports:
    - ☐ EKG
    - ☐ achocardiogram
    - ☐ Pulmonary function tests (PFTs)
  - ☐ Biopsy/Pathology reports including:
    - ☐ Bone marrow biopsy
    - ☐ Lymph node biopsy (as appropriate)
  - ☐ Laboratory reports

Visit our website at blueshieldca.com