Prior Authorization Request for Transplant

Louisiana Department of Health and Hospitals
Bureau of Health Services Financing

Date of Request: _____/ _____/ _____ _____ Original Request _____ Re-Evaluation Request

1) Patient's Name _____ 2) Date of Birth _____/_____/_____

3) Patient's Medicaid Identification Number (13-digits): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

4) Type of Transplant: _____ 5) Primary Diagnosis: _____

6) Secondary Diagnosis: _____ 7) Procedure Description: _____

8) Prognosis (with and without transplant, specifying morbidity, mortality, life expectancy and any other considerations:

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9) Patient's history of present illness is attached and includes the following: _____ Yes _____ No

_____ Pertinent social history, clinical findings, consults, and key test results (representing the patient's current status).

10) Copy of Transplant Selection Committee's Notes and/or Minutes is attached and signed by a Transplant Committee Physician and includes the following information: _____ Yes _____ No

_____ Listing of Committee members present (Name & Title), their discussions including any psychosocial concerns, e.g., drug or alcohol abuse, on patient suitability, quality of life and compliance.

11) Do Urgent or Emergency conditions exist? _____ Yes _____ No (If Yes, please attach explanation)

NOTE: For each item above, please attach additional information to support your request for transplant(s)

Emergency Requests can be submitted by faxing all documentation to:

DXC PRIOR AUTHORIZATION DEPARTMENT (EMERGENCY TRANSPLANT REQUEST) AT (225) 929-6803

I certify that the requested transplant is not investigational or experimental and is regarded as standard therapy by the medical community. This transplant program is in compliance with DHH Medicaid transplant registration and approval requirements for organ or tissue. Our transplant program will notify you if there are pertinent changes between approval and actual date of transplant that could necessitate reconsideration of the request. We are submitting or preparing to submit scientific documentation for recent applicable transplant developments.

12) _____
(Physician Name and Title, Please Print)

13) _____
(Physician Signature and Title)

14) _____
(Transplant Coordinator or Contact Person)

15) _____
(Telephone Number/Fax Number)

16) Site Where Transplant is to be Performed (Hospital Name & Address) _____

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TP – 01 FORM, Reissued 05/2011

Mail to: DXC/ La. Medicaid, Prior Authorization Dept., P. O. Box 14919, Baton Rouge, LA 70898-4919

Telephone Number for DXC Prior Authorization Dept. (800) 488-6334 or (225) 928-5263