AmeriHealth Caritas Iowa

Transplant Prior Authorization Request Form

Please complete all appropriate fields. Fax completed form and all pertinent clinical information related to your request to 1-844-211-0974.

Transplant prior authorizations require

- History and physical (within the past one year).
- Cardiopulmonary status: electrocardiogram (EKG), echocardiogram, chest x-ray (CXR), pulmonary function test (PFT) if smoking history, and stress test if indicated.
- Dental clearance by a dentist (within the past six months).
- Psychosocial evaluation (within the past one year) unless significant status change.
- Blood chemistry: electrolytes, blood urea nitrogen (BUN), creatinine, complete blood count, and liver profile (within the past one year).
- Any other lab testing as indicated by history.
- Infectious disease screening:
  - Current human immunodeficiency virus (HIV) and hepatitis panel.
  - Tuberculosis (TB) if indicated (case dependent).
- Age >50: colon cancer screening (within the past three years).
- Women age >21: Pap smear.
- Women age >50: mammogram (within the past two years).
- Documentation of no drug or alcohol misuse by history; drug or alcohol free for minimum of six months.

Organ-specific information

- Heart and heart/lung: cardiac catheterization, peak VO2 mL/kg/min.
- Liver: computed tomography (CT) scan or magnetic resonance imaging (MRI) of abdomen, liver biopsy (if indicated), and Model for End-Stage Liver Disease (MELD) or Pediatric End-Stage Liver Disease (PELD) score with documentation.

Bone marrow transplants or stem cell transplants

- Bone marrow biopsy.
- Karnofsky score or Eastern Cooperative Oncology Group (ECOG) grade.
- Evidence of chemotherapy response.
- Post-chemotherapy echocardiogram, PFT, electrolytes, BUN, and creatinine.
- MRI with gadolinium contrast for primary (AL) amyloidosis diagnosis only.

Patient information

Medicaid number:	AmeriHealth Caritas Iowa member ID number:
Patient name:	Date of birth:
Address:	

Facility and surgeon information

Transplant facility:
Address:
Facility National Provider Identifier (NPI) number:
Facility tax ID number:
Transplant surgeon name:
Transplant surgeon NPI number:

Codes

ICD-10 diagnostic codes:
CPT codes:

AmeriHealth Caritas Iowa

Transplant Prior Authorization Request Form

Please complete all appropriate fields. Fax completed form and all pertinent clinical information related to your request to 1-844-211-0974.

Preparer's information	
Name:	
Phone:	Fax:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review, or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Preparer signature: (Must match preparer listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish, by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.