Bone marrow / peripheral stem cell or other blood cell transplant prior authorization form

See the Bone Marrow/Peripheral Stem Cell/or Blood Cell Transplantation medical policy (#91066) for specific criteria that must be met for coverage.

Is your request for gene and cell therapies? Use our Oncology drug request form or Medical drug authorization request form to submit your request.

☐ Check if requesting on behalf of a Cigna-participating provider

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Member information

Member last name		Member first name	
Priority Health ID#		Date of birth	

☐ **Transplant Evaluation** ☐ **HLA Typing** – *if applicable*

Date of evaluation	
Primary diagnosis description	
Diagnosis code(s)	

☐ **Transplant Listing** Date of listing: _____

☐ Autologous ☐ Allogeneic
☐ Related ☐ Unrelated ☐ Gene & cell treatment
☐ Bone Marrow ☐ Peripheral Stem Cell ☐ Umbilical Cord Stem Cell

Admission for Transplant ☐ Inpatient ☐ Outpatient

Date of admission		Date of transplant	
Primary procedure description		Procedure code(s) - *CPT*	

Requested by:

Provider name		Provider tax ID	
Address		Specialty	
		Contact name	
Provider NPI		Phone	Fax

All fields must be complete and legible for prior authorization review. Clinical documentation may be requested at the health plan's discretion.

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Fax completed form to **888.647.6152** Questions? Call our Provider Helpline at 800.942.4765.

Directed to:

Provider name		Facility name	
Provider tax ID	Provider NPI	Facility tax ID	
Address		Address	
Phone	Fax	Phone	Fax
Contact name		Contact name	

Clinical indication

All fields must be complete and legible for prior authorization review. Clinical documentation may be requested at the health plan's discretion.

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