Solid organ transplant prior authorization form

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

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Date of request: _____

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

Member information

Member last name		Member first name	
Priority Health ID#		Date of birth	
Organ(s)			

☐ **Transplant Evaluation** ☐ **HLA Typing** ☐ **Listing start date**

Date of service	
Primary diagnosis description	
Diagnosis code(s)	

☐ **Transplant Listing**

☐ Transplant institution's selection criteria has been met

☐ Kidney	☐ Heart	☐ Lung
☐ Pancreas Transplant Alone (PTA)	☐ Pancreas after Kidney (PAK)	☐ Simultaneous Pancreas-Kidney (SPK)
For the transplants listed below, Priority Health's criteria must be met in addition to the transplanting institution's selection criteria. See Transplantation of Solid Organs medical policy #91272.		
☐ Liver	☐ Islet Cell	☐ Intestinal
☐ Small Bowel / Liver	☐ Multivisceral – small bowel / liver and/or stomach, pancreas, colon	

☐ **Admission for Transplant**

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

Requested by

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

Form continues on the next page

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

Directed to

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

Other indications not listed above

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

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