

TRANSPLANT REFERRAL FORM

Date _____

Referral Source: TPA Other

Request for Large Case Management

Transplant Referral

Plan Sponsor _____ Policy Year _____

PATIENT/MEMBER INFORMATION

Primary Insured _____ Social Security Number _____

Date of Birth _____ Female Male

Patient Name _____ Social Security Number _____

Date of Birth _____ Female Male Telephone Number _____

Relationship to Insured: Self Spouse Dependent Child Other (describe) _____

Patient's Effective Date _____ Primary Secondary Medicare Eligible

MEDICAL INFORMATION

Primary Diagnosis _____ Procedure or Transplant Type _____

Evaluation Date _____ Procedure Admission Date _____ Discharge Date _____

Facility/Hospital Name _____ Telephone Number _____

Street Address _____ City _____ State _____ Zip Code _____

Physician's Name _____ Telephone Number _____

Street Address _____ City _____ State _____ Zip Code _____

CLAIM INFORMATION

Third Party Administrators Name _____ Telephone Number _____

Street Address _____ City _____ State _____ Zip Code _____

Claims Paid to Date (CPTD) \$ _____ Claims Pended \$ _____ Claims Denied \$ _____

Eligibility Status _____ Vendor/TPA Contact _____

Is the Facility/Hospital in the PPO Network YES (Name of Network: _____) NO (If No, please contact SLG Benefits immediately).

Has Large Case Management been implemented? Yes No Name of Case Manager _____

Case Management Telephone Number _____ Fax Number _____

TRANSPLANT REFERRAL FORM

SLG strives to expedite all requests concerning excess loss coverage for a proposed transplant. Please provide SLG Benefits & Insurance with the following essential information so we may begin the review process:

1. Please supply the title of the proposed protocol as well as a copy of the transplant institution's IRB-approved protocol.
2. Is the protocol part of a Feasibility, Pilot or Phase I, II or III study?
3. In the case of a study, is it currently part of a multi-center National Cancer Institute or NIH Trial?
4. In the case of a bone marrow transplant, is this an autologous or allogeneic transplant? Myeloablative or non-myeloablative?
5. Does the transplant include chemotherapeutic agents that are not approved by the FDA for the patient's malignancy or are there any proposed off-label drug uses?
6. Does the transplant include any orphan drugs?
7. Is a tandem transplant proposed?
8. In the case of a Bone Marrow Transplant, has the patient received a prior Bone Marrow Transplant? If so, please indicate the date and description.
9. Please provide a copy of the evaluation to include the history and physical, all diagnostic studies that were performed during the work-up in addition to a copy of the entire transplant protocol. If no formal protocol is being utilized, we will need a copy of the transplant orders, or written documentation that outlines the proposed treatment regimen.
10. Please provide a copy of the TPA's transplant determination or the written details of the current position.

Please note: It is the responsibility of the Plan Sponsor or their designated TPA to determine coverage based on the benefit plan document. The results of our review should not replace or supercede that of the Plan Sponsor or their designated TPA.

So we may expedite our medical review, please forward responses to these questions as soon as possible. If applicable, please include any external medical opinions you have obtained concerning the proposed transplant.