

Post Transplant Rejection Treatment Authorization

Date: _____ Treatment Start Date: _____
Patient Name: _____ DOB: _____
Patient Phone Number: _____ ID#: _____
Health Plan Name: _____ Fax#: _____
Phone#: _____ Health Plan Representative: _____

If procedure must be performed inpatient, please specify reason below

Inpatient (Reason: _____) **Outpatient**
Reason for Treatment: Rejection Type: _____
 Other: _____ Patient height: _____ Weight: _____
Plasma Exchange: Yes No # Treatments: _____
Frequency: _____ Albumin: Yes No FFP: Yes No
IVIg: Yes No Brand: _____ Dose/Frequency: _____
Velcade: Yes No Dose/Frequency: _____
Rituximab: Yes No Dose/Frequency: _____
Other Med: _____ Dose/Frequency: _____
Additional Comments: _____

Methodist Transplant Coordinator _____ Date _____

Transplant Nephrologist Signature _____ Date _____

Is treatment requested a covered benefit for the patient? Yes No
Number of therapies authorized: _____ Comments: _____
Authorization: Denied Granted Authorization #: _____

Methodist Case Coordinator _____ Date _____

Administrative Authorization to Proceed with Treatment:

Proceed with Treatment: Yes No

Director of Transplant Clinical Operations _____ Date _____

If patient requires additional rejection therapy, MDMC post transplant coordinator is to notify the MDMC Case Coordinator so that additional authorization can be sought. If authorization is not given, Case Coordinator is to notify the transplant team so that that a peer-to-peer can be scheduled with health plan medical director.