BMT Bundle Excluded Drugs-Pre-approval Form

This is a pre-requisite form provided upon request for the **BMT Bundle Excluded drugs.**

Kindly fill in all the requested information given below. This is a mandatory step to proceed further. Failure to provide information relevant to approval will delay the processing of the BMT Bundle excluded drugs.

GENERAL INFORMATION

- Member's Name:
- Member Card #:
- Age:
- Gender: ☐ Female ☐ Male
- Date: / /

Encounter Type

- Provider code & Name:
- IP/Day care/OP:
- Clinician ID & Specialty

MEDICATION REQUESTED-1

- BMT Excluded Medication:
- Medication Name:
- Diagnosis (FDA labelled):
- Dose and Duration
- IP Admission Date:
- IP Discharge Date:
- Specify if it is a Home taking medication:
- Prescription copies and medical report investigation results (Lab results) that justify the requested diagnosis attached? YES/NO (If no, please attach)

MEDICATION REQUESTED-2

- BMT Excluded Medication: _____
- Medication Name: _____
- Diagnosis (FDA labelled): _____
- Dose and Duration _____
- IP Admission Date: _____
- IP Discharge Date:
- Specify if it is a Home taking medication: _____
- Prescription copies and medical report investigation results (Lab results) that justify the requested diagnosis attached? YES/NO (If no, please attach)

Note-If you are requesting approval for more than two excluded medications, please complete and attach an additional copy of this same form.