

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.