

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:	<input type="checkbox"/> Female <input type="checkbox"/> 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.