Kidney Transplant Request for Coverage Form

Point32Health

Harvard Pilgrim Health Care TUFTS Health Plan

This form should be completed by the person who has a thorough knowledge of the patient's current clinical presentation and his/her treatment history. Please complete all parts as clearly and as specifically as possible. Omissions, generalities, and illegibility will result in the form being returned for completion or clarification.

Please fax this form and the clinical documentation requested below to the appropriate fax number:

- **Harvard Pilgrim Health Care Commercial** ..... Fax: 800-232-0816
- **Tufts Health Plan Commercial** ..... Fax: 617-972-9409
- **Tufts Health Direct** — Health Connector commercial plan ..... Fax: 888-415-9055
- **Tufts Health Together** — A MassHealth Plan ..... Fax: 888-415-9055
- **Tufts Health RITogether** — A Rhode Island Medicaid Plan ..... Fax: 857-304-6404
- **Tufts Health One Care** ..... Fax: 857-304-6304

Demographic information

Patient name: ID # Date of birth:

PCP or Referring Provider:

Transplant Physician: Transplant Facility:

Evaluation date: Listed date:

Transplant Coordinator: Phone:

Financial Coordinator: Phone:

Current diagnosis(es)	ICD Code	Comorbid diagnoses

CPT Code(s) Requested:

Please answer the following questions *(Questions not applicable to Tufts Health One Care, see MassHealth)*

Is the patient receiving dialysis? ☐ Yes ☐ No If *Yes*, how long?

What is the patient's current Glomerular Filtration Rate?

Does the patient have any unresolved psychosocial concerns or a history of non-compliance with medical management?	☐ Yes ☐ No
Does the patient have any active or uncontrolled alcohol use disorder or substance use disorder?	☐ Yes ☐ No
Does the patient have any serious health conditions that create an inability to tolerate transplant surgery or post-transplant care?	☐ Yes ☐ No
Is the patient HIV positive?	☐ Yes ☐ No
Does the patient have active malignancy, including metastatic cancer or recent malignancy with high risk of recurrence?	☐ Yes ☐ No
Does the patient have a nonfunctioning or abnormal lower urinary tract that has not been evaluated and treated by a urologist?	☐ Yes ☐ No
Does the patient have any uncontrolled/untreatable infections?	☐ Yes ☐ No
Does the patient have any progressive central neurodegenerative disease?	☐ Yes ☐ No
Does the patient have any active pulmonary disease?	☐ Yes ☐ No
Has the patient had a recent stroke or transient ischemic attack?	☐ Yes ☐ No
Does the patient have active Hepatitis B or Hepatitis C infection?	☐ Yes ☐ No
Does the patient have AL amyloidosis with significant extrarenal involvement?	☐ Yes ☐ No
Does the patient have a cardiac ejection fraction of < 30%?	☐ Yes ☐ No
Does the patient have advanced ilio-femoral vascular disease?	☐ Yes ☐ No
Does the patient have advanced liver disease or decompensated cirrhosis?	☐ Yes ☐ No

Required documentation

☐ **Letter of Medical Necessity,** including the following: summary of course of illness, current medications, smoking, alcohol, and drug abuse history

☐ **Medical records,** including physical exam, medical history, and family history

☐ **Laboratory assessment** including serologies and CD4 levels

CLEAR FORM