Liver 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: MELD Score:

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 NCD and MassHealth)*

Is end-stage liver disease present?	☐ Yes ☐ No
Is the patient HIV positive?	☐ Yes ☐ No
Does the patient have an untreated/unstable cardiopulmonary disease?	☐ Yes ☐ No
Does the patient have any serious health conditions that create an inability to tolerate transplant surgery or post-transplant care?	☐ Yes ☐ No
Has the patient had extrahepatic malignancy within the past 5 years? (excludes superficial skin cancers) or those not meeting oncologic criteria for cure)	☐ Yes ☐ No
Does the patient have any evidence of extrahepatic, lymphatic or vascular tumor spread?	☐ Yes ☐ No
Does the patient have any uncontrolled/untreatable infections?	☐ Yes ☐ No
Has the patient had active alcohol or uncontrolled alcohol use disorder in the past 3 months?	☐ Yes ☐ No
Does the patient have an active or uncontrolled substance use disorder?	☐ Yes ☐ No
Does the patient have any unresolved psychosocial concerns or a history of non-compliance with medical management?	☐ 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