Lung Transplant Request for Coverage Form

Point32Health

Harvard Pilgrim Health Care | TUFTS Health Plan

Check one: Single Lung ☐ Bilateral Lung ☐ Heart-Lung ☐ Living Lobar Lung ☐

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 end stage pulmonary disease present?	☐ Yes ☐ No		
Is the patient's life expectancy < 3 years?	☐ Yes ☐ No	Is the patient ambulatory with rehab potential?	☐ Yes ☐ No
Is there a high (>80%) likelihood of 5-year post-transplant survival?			☐ Yes ☐ No
Does the patient have malignancy with high risk of recurrence?			☐ Yes ☐ No
Does the patient have an uncontrolled or an untreatable infection?			☐ Yes ☐ No
Does the patient have any serious health conditions that create an inability to tolerate transplant surgery or post-transplant care?			☐ Yes ☐ No
Does the patient have an active tuberculosis infection?			☐ Yes ☐ No
Does the patient have significant dysfunction of the liver, kidney or central nervous system?			☐ Yes ☐ No
Does the patient have an untreatable hematologic disorder?			☐ Yes ☐ No
Does the patient have acute coronary syndrome or has the patient been treated for a myocardial infarction within the past 30 days?			☐ Yes ☐ No
Has the patient had any progressive cognitive impairment or been treated for a stroke within the past 30 days?			☐ Yes ☐ No
Does the patient have any active inhaled substance use (e.g., smoking cigarettes, marijuana smoking, inhaling e-cigarettes, vaping)?			☐ Yes ☐ No
Does the patient have any active or uncontrolled alcohol use disorder or substance use disorder?			☐ Yes ☐ No
Does the patient have any unresolved psychosocial concerns or a history of non-compliance with medical management?			☐ Yes ☐ No
Is the patient HIV positive?			☐ 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