Pancreas Transplant Request for Coverage Form

Point32Health

Harvard Pilgrim Health Care | TUFTS Health Plan

Check one: Pancreas ☐ Islet Cell ☐ Staged Kidney-Pancreas ☐ Simultaneous Kidney-Pancreas ☐

Note: If kidney transplant is also being requested, complete the Kidney Transplant Request for Coverage Form.

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 NCD and MassHealth)*

Does the patient have a consistent failure of insulin-based management to prevent acute complications?	☐ Yes ☐ No
Does the patient have clinical and emotional problems with exogenous insulin therapy that are so severe as to be incapacitating?	☐ Yes ☐ No
Does the patient have a history of frequent, acute and severe metabolic complications requiring current hospitalization?	☐ Yes ☐ No
Is the patient's life expectancy projected to be < 5 years?	☐ Yes ☐ No
Does the patient have active malignancy, including metastatic cancer or recent malignancy with high risk of recurrence?	☐ Yes ☐ No
Is the patient HIV positive?	☐ Yes ☐ No
Does the patient have any uncontrolled/untreatable infections?	☐ Yes ☐ No
Does the patient have any serious conditions that create an inability to tolerate transplant surgery or post-transplant care?	☐ Yes ☐ No
Does the patient have any moderate to severe dysfunction of lung, liver, and/or central nervous system (e.g, cirrhosis, portal hypertension, chronic obstructive pulmonary disease, dementia, or neurologic deficits)?	☐ Yes ☐ No
Does the patient have advanced vascular disease?	☐ Yes ☐ No
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

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