Stem Cell 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 forward this form and clinical documentation requested below to the following address:

Tufts Health Plan Commercial
Commercial Care Management
1 Wellness Way
Canton, MA 02021-1166
Fax: 617.972.9470

Tufts Health Public Plans
Medical Management, Intake Services
1 Wellness Way
Canton, MA 02021-1166
Fax: 888.415.9055

Tufts Health RITogether
Medical Management, Intake Services
1 Wellness Way
Canton, MA 02021-1166
Fax: 857.304.6404

Demographic Information

Patient name:	Patient DOB:	
Member ID #:	PCP or Referring Provider:	
Transplant Physician:	Transplant facility:	
Will the chemotherapy be received inpatient or outpatient? Inpatient ☐ Outpatient ☐		
Will the stem cell transplant be received inpatient or outpatient? Inpatient ☐ Outpatient ☐		
Transplant Coordinator:	Phone #:	Evaluation date:
Financial Coordinator:	Phone #:	

Current Diagnosis(es)	ICD Code	Comorbid Diagnoses

Transplant Information
Check off one of the following stem cell transplants and source of stem cells

Stem Cell Transplant Type	☐	Stem Cell Source	☐
Autologous	☐	Bone Marrow	☐
Allogeneic	☐	Peripheral Blood	☐
Reduced Intensity Allogeneic (Mini Allogeneic)	☐	Umbilical Cord Blood	☐
Is this a tandem transplant request? Yes ☐ No ☐		Date of first transplant:	
		Date of second transplant:	

Please answer the following questions

Were there any previous stem cell transplants? Yes ☐ No ☐	
If yes, please indicate type: Autologous ☐ Allogeneic ☐ Reduce Intensity Allogenic ☐ Allogenic ☐	Date of Procedure(s):
Did any previous stem cell transplant fail? Yes ☐ No ☐	Date and Type of Procedure(s):
Were any of the previous stem cell transplants part of a tandem transplant treatment? Yes ☐ No ☐	Date and Type of Procedure(s):

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, family history, pulmonary test, cardiac function studies
- ☐ Patient's ECOG performance status 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
- ☐ Laboratory assessment including serologies and CD4 levels
- ☐ HLA Tissue Typing
- ☐ Current bone marrow biopsy results
- ☐ CAT scan or MRI results to show staging where appropriate
- ☐ Supporting documentation to show response to chemotherapy

Provider Services