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, please 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 forward this form and clinical documentation requested below to the following address:

- **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 OneCare Plan** Fax: 781-393-2607

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 a history of frequent, acute and severe metabolic complications requiring current hospitalization?	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 malignancy within the past 5 years?	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 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 a history of CABG, PTCA, or MI?	Yes	No
Does the patient have advanced Ilio-Femoral Vascular disease?	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