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:

- For Tufts Health Plan Commercial, Tufts Health Freedom Plan: 617.972.9470
- Tufts Health Freedom Plan products: Fax: 617.972.9470
- 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 Unify-OneCare Plan; Fax: 857.304.6304

Demographics

Patient Name:	Patient DOB:
ID #:	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

Is the patient receiving dialysis? Yes ☐ No ☐	If yes, how long? _____	What is the patient's current Glomerular Filtration Rate? _____
Is the patient receiving a living organ ☐ or a cadaveric organ? ☐		
Does the patient have any unresolved psychosocial concerns or a history of non-compliance with medical management? Yes ☐ No ☐		
Has the patient had active alcohol, tobacco, or nicotine delivery system use or substance abuse within the past 6 months? 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 a history of malignancy within the past two years, except within the past five years for breast cancer, malignant melanoma and colorectal cancer? Yes ☐ No ☐		
Does the patient have a nonfunctioning or abnormal lower urinary tract that has not been evaluated and treated by a urologist? Yes ☐ No ☐		
Does the patient have any uncontrolled/untreatable infections? Yes ☐ No ☐	Does the patient have an active malignancy? Yes ☐ No ☐	
Does the patient have treated cerebrovascular disease? Yes ☐ No ☐	Does the patient have any untreated active coronary artery disease? Yes ☐ No ☐	
Does the patient have any active pulmonary diseases? Yes ☐ No ☐ If yes, please explain:	Is the patient HIV positive? Yes ☐ No ☐	
Does the patient have active Hepatitis B or Hepatitis C infection? Yes ☐ No ☐	Does the patient have a cardiac ejection fraction of < 30%? Yes ☐ No ☐	
Does the patient have a body mass index of > 38 kg/m^2? Yes ☐ No ☐		
Does the patient have advanced ilio-femoral vascular disease? Yes ☐ No ☐		
Does the patient have advanced liver 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

Provider Services