Liver 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: 617.972.9409
- Tufts Health Freedom Plan products: 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 Unify-OneCare Plan; Fax: 781.393.2607

Demographic Information

Patient Name:		Patient DOB:
ID #:	PCP or Referring Provider:	
Transplant Physician:	Transplant Facility:	
Evaluation Date:	Listed Date:	MELD Score:
Transplant Coordinator:	Phone #:	
Financial Coordinator:	Phone #:	

Current Diagnosis(es)	ICD 9 Code	Comorbid Diagnoses

Please answer the following questions

Is end-stage liver disease present? Yes ☐ No ☐
Is the patient a living organ ☐ or a cadaveric organ? ☐
Is the patient HIV positive? Yes ☐ No ☐
Does the patient have an untreated/unstable cardiopulmonary disease? Yes ☐ No ☐
Does the patient have any serious health conditions that create an inability to tolerate transplant surgery or post-transplant care? Yes ☐ No ☐
Has the patient had an extrahepatic malignancy within the past 5 years? Yes ☐ No ☐
Does the patient have or has the patient had hepatocellular carcinoma? Yes ☐ No ☐
Does the patient meet oncologic criteria for cure? Yes ☐ No ☐
Has the patient had active alcohol, tobacco, nicotine delivery system or substance abuse in the past 6 months? Yes ☐ No ☐
Does the patient have any unresolved psychosocial concerns or a history of non-compliance with medical management? 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