



Lung Transplant Request for Coverage Form

Check one: Single Lung Bilateral Lung Heart-Lung Living Lobar Lung

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:	
Transplant Coordinator:		Phone #:	
Financial Coordinator:		Phone #:	

Current Diagnosis(es)	ICD Code	Comorbid Diagnoses

CPT Code(s) Requested: _____

Please answer the following questions:

Is end stage pulmonary disease present? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the patient a living organ <input type="checkbox"/> or a cadaveric organ? <input type="checkbox"/>
Is the patient's current medical therapy ineffective? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the patient's life expectancy < 3 years? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the patient ambulatory with rehab potential? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the patients BMI >17kg/m ² or <30kg/m ² ? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the patient HIV positive? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the patient have an uncontrolled or an untreatable infection? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the patient have an uncured neoplasm? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the patient have any serious health conditions that create an inability to tolerate transplant surgery or post-transplant care? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the patient have significant dysfunction of the liver, kidney or central nervous system? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the patient have significant Coronary Artery Disease or Right or Left Ventricular Dysfunction? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Has the patient had active alcohol, tobacco, or nicotine delivery system use or substance abuse in the past 6 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the patient have any unresolved psychosocial concerns or a history of non-compliance with medical management? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is the patient Hepatitis B sAg+? Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the patient have active or chronic Hepatitis C? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the patient ventilator dependent and being actively treated for acute respiratory failure? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Required Documentation

<input type="checkbox"/> Letter of Medical Necessity, including the following: summary of course of illness, current medications, smoking, alcohol, and drug abuse history
<input type="checkbox"/> Medical records, including physical exam, medical history, and family history
<input type="checkbox"/> Laboratory assessment including serologies and CD4 levels

[Provider Services](#)