Pancreas Transplant Request for Coverage Form

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:

- 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:

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 ☐
Has the patient had active alcohol, tobacco, or nicotine delivery system use or substance abuse in the past 6 months? 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

Provider Services