TUFTS Health Plan

Tufts Health RITogether

Pancreas Transplant Request Form

Please fax form to: 857.304.6404

Today's date: _____/_____/_____

Please 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 Form found at tuftshealthplan.com/provider.

This form should be completed by the provider 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 to the following address or fax number:

Tufts Health Plan
Attn: Medical Management Intake Services
75 Fountain Street, Floor 1
Providence, RI 02903

Fax: 857.304.4093

Member 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	CPT code	Comorbid diagnoses

CPT Code(s) Requested: _____

Please answer the following questions:

1. Does the patient have a consistent failure of insulin-based management to prevent acute complications? ☐ Y ☐ N
2. Does the patient have a history of frequent, acute and severe metabolic complications requiring current hospitalization? ☐ Y ☐ N
3. Does the patient have clinical and emotional problems with exogenous insulin therapy that are so severe as to be incapacitating? ☐ Y ☐ N
4. Does the patient have a history of malignancy within the past 5 years? ☐ Y ☐ N
5. Is the patient HIV-positive? ☐ Y ☐ N
6. Does the patient have any uncontrolled/untreatable infections? ☐ Y ☐ N
7. Does the patient have any serious conditions that create an inability to tolerate transplant surgery or post-transplant care? Y ☐ N
8. Does the patient have any unresolved psychosocial concerns or a history of non-compliance with medical management? ☐ Y ☐ N
9. Has the patient had active alcohol, tobacco or nicotine delivery system use or substance abuse in the past 6 months? ☐ Y ☐ N
10. Does the patient have a history of CABG, PTCA or MI? ☐ Y ☐ N
11. Does the patient have advanced Ilio-femoral vascular disease? ☐ Y ☐ N

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