TUFTS Health Plan

Tufts Health RITogether
Stem Cell Transplant Request Form
Please fax form to: 857.304.6404

Today's date: _____/_____/_____

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
705 Mount Auburn Street
Watertown, MA 02471
Fax: 857.304.6404

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

Transplant information

Please check off one of the following stem cell transplants and source of stem cells

Stem cell transplant type	Stem cell source
☐ Autologous	☐ Bone Marrow
☐ Allogenic	☐ Peripheral blood
☐ Reduced intensity allogeneic (Mini Allogeneic)	☐ Umbilical cord blood
Is this a tandem request? ☐ Y ☐ N	Date of first transplant: _____/_____/_____
Date of first transplant: _____/_____/_____	Date of second transplant: _____/_____/_____

Forms available at tuftshealthplan.com/provider
Tufts Health Public Plans Rhode Island provider services number: 844.301.4093
5986 05037

TUFTS Health Plan

Tufts Health RITogether
Stem Cell Transplant Request Form
Please fax form to: 857.304.6404

Please answer the following questions:

Were there any previous stem cell transplants? ☐ Y ☐ N
If yes, please indicate type: ☐ Autologous ☐ Allogeneic ☐ Reduced intensity allogeneic ☐ Allogenic
Date of procedure(s): _____
Did any of previous stem cell transplants fail? _____
Were any of the previous stem cell transplants a part of a tandem transplant treatment? ☐ 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, family history, and pulmonary test cardiac function studies
- ☐ Patient's ECOG performance status 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
- ☐ Laboratory assessment including serologies and CD4 levels
- ☐ HLA Tissue Typing
- ☐ Current bone marrow biopsy results
- ☐ CAT scan or MRI results to show staging where appropriate
- ☐ Supporting documentation to show response to chemotherapy

Forms available at tuftshealthplan.com/provider
Tufts Health Public Plans Rhode Island provider services number: 844.301.4093
5986 05037