BlueCare Tennessee
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Chattanooga, TN 37402
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BlueCare℠
TennCare*Select*

Transplant Fax Form

Member name: _____

Member ID number: _____

DOB: _____

Date of request: _____

Transplant MD: (Name, provider number/NPI number, phone number)

Contact person name and number:

Transplant facility and provider number/NPI number:

Will transplant be: Outpatient Inpatient

Diagnosis and ICD-9:

Procedure code(s):

Type of transplant:

With each type of transplant please include history and physical, and psychosocial evaluation.

All clinical information must be dated in last seven (7) months for each type of transplant.

Please see needed criteria for each type of transplant and include these and all pertinent clinical information.

Liver Transplant (Select reason and provide supporting documentation.)

☐ Acute liver failure

☐ Severe chronic liver failure as indicated by **1 or more** of the following:

- Child-Turcotte-Pugh class score
- Model for end-stage liver disease (MELD)
- Children with chronic liver disease who deviate from normal growth curves or show evidence of hepatic dysfunction or portal hypertension [B]
- Hepatorenal syndrome(13)
- Major complication (eg, variceal bleeding, hepatic encephalopathy, ascites)
- Alternative scoring or indicator of severe hepatic dysfunction

☐ Metabolic diseases with the metabolic defect in the liver

☐ Liver tumors that are not otherwise resectable and have not metastasized outside the liver

☐ Failure of previous liver transplant

Provide additional information for liver transplant request:

☐ Yes ☐ No: sustained increases of intracranial pressure greater than 40 mm Hg

☐ Yes ☐ No: cerebral perfusion pressure not less than 60 mm Hg

☐ Yes ☐ No: irreversible brain damage

☐ Yes ☐ No: advanced HIV disease, HIV-positive liver transplant candidates should have CD4 counts greater than 100/mm^3 (0.1 x10^9/L) and plasma HIV RNA levels below 200 copies per milliliter, or the chance of becoming undetectable with use of optional drugs for successful treatment after transplant.(7) [A]

☐ Yes ☐ No: Extrahepatic malignancy

☐ Yes ☐ No: cholangiocarcinoma

☐ Yes ☐ No: hemangiosarcoma

☐ Yes ☐ No: active sepsis

☐ Yes ☐ No: active alcoholism or substance abuse(8)

Mean pulmonary artery pressure

☐ Yes ☐ No: advanced cardiac or pulmonary disease

☐ Yes ☐ No: able to comply with immunosuppression protocol

☐ Yes ☐ No: anatomic abnormalities precluding liver transplant

HT Wt BMI

KIDNEY

☐ Yes ☐ No: end stage renal disease

Glomerular filtration rate:

HIV status:

IF positive provide: CD4 count HIV-1 RNA Length of time on anti-retroviral therapy

Any complications from AIDS

Comorbidites

Previous malignancies or cancer free for 5 years:

Must have drug screen.

☐ Yes ☐ No: reversible renal disease

LUNG TRANSPLANT

Include reason alternative to lung transplant is not available.

Medical therapies failure:

Indicate the reason for lung transplant and include clinical information.

☐ COPD

☐ Cystic fibrosis

☐ Idiopathic pulmonary fibrosis

☐ Fibrotic nonspecific interstitial pneumonitis

☐ Pulmonary arterial hypertension

☐ Lymphangioleiomyomatosis

☐ Pulmonary Langerhans cell histiocytosis

☐ Sarcoidosis with New York Heart Association functional class III or IV

Stem cell transplant:

Autologous Allogeneic Diagnosis

Include clinical information supporting the treatment for the specific diagnosis.