



Drug Prophylaxis <sup>c</sup>						
Description	Date dispensed (mm/dd/yyyy)					
<input type="checkbox"/> Nystatin						
<input type="checkbox"/> Valacyclovir <sup>b</sup>						
<input type="checkbox"/> Isoniazid (INH)						
<input type="checkbox"/> Cotrimoxazole						
<input type="checkbox"/> Valganciclovir <sup>a</sup>						
<sup>a</sup> Valganciclovir can be shifted to valacyclovir if with severe leukopenia <sup>b</sup> Valacyclovir can be shifted to valganciclovir if with CMV conversion <sup>c</sup> Applicable to kidney recipients during the first year after kidney transplant procedure						

Drug Level Monitoring*	
Description	Date (mm/dd/yyyy)
<input type="checkbox"/> Tacrolimus (trough)	1. _____ 2. _____ 3. _____ 4. _____
<input type="checkbox"/> Cyclosporine (trough or C2)	5. _____ 6. _____ 7. _____ 8. _____ 9. _____
<input type="checkbox"/> Sirolimus (trough)	10. _____ 11. _____ 12. _____ 13. _____ 14. _____
<input type="checkbox"/> Everolimus (trough)	15. _____ 16. _____ 17. _____ 18. _____ 19. _____
<input type="checkbox"/> Mycophenolate AUC	20. _____ 21. _____ 22. _____ 23. _____ 24. _____
*The following rules shall apply: 1. Maximum availment of twenty-four (24) times; Applicable to kidney recipients during the first year after kidney transplant procedure 2. Maximum availment of 4x a year; Applicable to kidney recipients starting from the 13th month after kidney transplant procedure	

Laboratory Tests*						
Description	Date (mm/dd/yyyy)					
As prescribed:						
<input type="checkbox"/> Complete blood count (CBC)						
<input type="checkbox"/> Creatinine						
<input type="checkbox"/> Sodium (Na)						
<input type="checkbox"/> Potassium (K)						
<input type="checkbox"/> Fasting blood sugar (FBS)						
<input type="checkbox"/> Serum glutamic pyruvic transaminase (SGPT)						
<input type="checkbox"/> Urinalysis						
<input type="checkbox"/> Urine total protein creatinine ratio (UTPCR) or Urine albumin creatinine ratio (UACR)						
<input type="checkbox"/> 24-hour urine protein						
<input type="checkbox"/> 24-hour urine albumin						
<input type="checkbox"/> Aspartate aminotransferase (AST)						
<input type="checkbox"/> Alanine transaminase (ALT)						
<input type="checkbox"/> GGT (gamma-glutamyl transferase)						
<input type="checkbox"/> Calcium						
<input type="checkbox"/> Phosphate						
<input type="checkbox"/> Magnesium						
<input type="checkbox"/> Intact parathyroid hormone (iPTH)						
<input type="checkbox"/> 25-OH Vit D						
Lipid profile:						
<input type="checkbox"/> Total cholesterol						
<input type="checkbox"/> High-density lipoprotein (HDL) cholesterol						
<input type="checkbox"/> Low-density lipoprotein (LDL) cholesterol						
<input type="checkbox"/> Triglycerides						

<b>Laboratory Tests*</b>						
Description	Date (mm/dd/yyyy)					
As indicated:						
<input type="checkbox"/> Albumin						
<input type="checkbox"/> Prothrombin time (PT)						
<input type="checkbox"/> Partial thromboplastin time (PTT)						
<input type="checkbox"/> HbA1c						
*Laboratory tests can be prescribed multiple times, subject to the amount limit per claim						

<b>Procedure</b>	
Description	Date (mm/dd/yyyy)
<input type="checkbox"/> Renal graft biopsy (Once a year, if indicated)	

<b>Diagnostic Tests</b>	
Description	Date (mm/dd/yyyy)
<input type="checkbox"/> Chest X-ray*	
<input type="checkbox"/> Whole abdominal ultrasound*	
<input type="checkbox"/> Renal graft doppler (as indicated)*	
*Once a year	

<b>Infectious Disease Monitoring</b>						
Description	Date (mm/dd/yyyy)					
<input type="checkbox"/> CMV IgM						
<input type="checkbox"/> CMV IgG						
<input type="checkbox"/> EBV IgM						
<input type="checkbox"/> EBV IgG						
<input type="checkbox"/> BKV-PCR						
*The following rules shall apply: <ol style="list-style-type: none"> <li>1. The laboratory test can be prescribed multiple times, if indicated</li> <li>2. Maximum availment of 12x; Applicable to kidney recipients during the first year after kidney transplant procedure</li> <li>3. Maximum availment of 4x per year; Applicable to kidney recipients starting from the 13th month after kidney transplant procedure</li> </ol>						

<b>Ancillary Services</b>					
Description	Date (mm/dd/yyyy)				
<input type="checkbox"/> Anti-HLA DSA (donor specific antibody) <sup>a</sup>					
<input type="checkbox"/> Serum Iron <sup>b</sup>					
<input type="checkbox"/> Ferritin <sup>b</sup>					
<input type="checkbox"/> Total iron binding capacity (TIBC) <sup>b</sup>					
<p>The following rules shall apply:</p> <p><sup>a</sup>Maximum availment of 2x if with suspicion of renal graft rejection and/or for monitoring of DSA; Applicable to kidney recipients during the first year after the kidney transplant procedure; then once a year starting from the 13th month after kidney transplant procedure</p> <p><sup>b</sup>Maximum availment of 12x; Applicable to kidney recipients during the first year after the kidney transplant procedure; then maximum of 6x per year starting from the 13th month after the kidney transplant procedure</p>					

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Nephrologist/Transplant Surgeon	(Printed name and signature) Parent/Legal Guardian
PhilHealth Accreditation No. _____ Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)