Annex A.2: Pre-authorization Checklist and Request Form for Heart Valve Repair and/or Replacement for Valvular Heart Disease (Pediatric)





Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

• Citystate Centre, 709 Shaw Boulevard, Pasig City

€ (02) 8662-2588 ⊕www.philhealth.gov.ph

PhilHealthOfficial X teamphilhealth

Case No._

| HEALTH FACILITY (HF) | | | | | | | | |
|---|--|---------------------------------|--|--|--|--|--|--|
| ADDRESS OF | HF | | | | | | | |
| A. PATIENT | Last Name, First Name, Middle Name, Suffix | SEX | | | | | | |
| | | \square Male \square Female | | | | | | |
| | PhilHealth ID Number: | | | | | | | |
| B. MEMBER | Last Name, First Name, Middle Name, Suffix | SEX | | | | | | |
| □ Same as above | | □ Male □ Female | | | | | | |
| (Answer only if the patient is a dependent) | PhilHealth ID Number: | | | | | | | |

Pre-authorization Checklist and Request Form

Heart Valve Repair and/or Replacement for Valvular Heart Disease (Pediatric)

Place a (✔) or appropriate remarks

| TYPE OF PROCEDURE* | Remarks |
|--|---------|
| Mitral valve replacement with tricuspid valve annuloplasty | |
| Aortic valve replacement with tricuspid valve annuloplasty | |
| Mitral valve replacement | 7 |
| Aortic valve replacement | |
| Mitral valve repair with Tricuspid valve repair | |
| Mitral valve repair | |

*The contracted HF shall select one surgical procedure to be performed on the patient

Place a (\checkmark) or appropriate remarks

| General Criteria | Remarks |
|---|---------|
| EUROscore II and STS score <5% mortality | |
| Life expectancy of more than five (5) years | |
| No previous history of Valvular Surgery | |
| Not in decompensated heart failure New York Heart Association (NYHA) Classification IV | |
| No other concomitant surgeries (CABG, Permanent Pacemaker | |
| Insertion [PPI], aortic root repair) planned with valve surgery | |



| General Criteria | Remarks |
|---|---------|
| No active malignancies | |
| No liver cirrhosis | |
| No previous cardiac or thoracic surgery | |
| 2D echo done within six (6) months | |

Place a (\checkmark) on the appropriate procedure to be performed and remarks

| Mitral valve replacement | Remarks |
|---|---------|
| 1. Age at least 15 years old but not more than 18 years and 364 days | |
| 2. Etiology: a. If rheumatic etiology-controlled activity with at least two (2) weeks anti-inflammatory Check inflammatory markers b. If with infective endocarditis and/or vegetation with negative blood CS completed at least 2 weeks antibiotic | |
| 3. Check any one of the following: a. SEVERE MITRAL STENOSIS MVA <1.5 with Wilkins valve score 9 or more) or combined with Mitral regurgitation, mild to moderate b. SEVERE MITRAL REGURGITATION i. Symptomatic with NYHA II ii. Vena contracta >0.7 cm, RF ≥50% iii. Left Ventricular end systolic diameter >/= 4; Or LVESD enlarged by z score; OR LV end diastolic diameter >/= 5.5 cm; iv. Preserved LV function ≥55% | |
| 4. Institution Valve team Approval for the following: a. Symptomatic NYHA III-IV b. With depressed LV function < 45 % c. Age 10-15 years old | |
| 5. Intraoperative TEE finding of Mitral regurgitation RF > 50% after MV repair | |

| ☐ Mitral valve replacement with tricuspid valve annuloplasty | Remarks |
|--|---------|
| 1. Age up to 18 years and 364 days old | |
| 2. With concomitant moderate to severe tricuspid regurgitation | |
| 3. Dilated TV annulus >/=4cm or index TV annulus >/=2.1 | |
| 4. Intraoperative TEE finding of TR moderate to severe with dilated TV annulus | |

| ☐ Mitral valve repair | Remarks |
|--|---------|
| 1. Age less than 15 years old | |
| 2. Check etiology a. If rheumatic etiology-controlled activity with at least 2 weeks anti-inflammatory (Check inflammatory markers) b. If with infective endocarditis and/or vegetation with negative blood CS completed at least 2 weeks antibiotic | |
| 3. SEVERE MITRAL REGURGITATION a. Symptomatic with NYHA II -III; b. Vena contracta >0.7 cm, RF >50%; c. Left Ventricular end systolic diameter >/= 4; Or LVESD enlarged by z score; OR LV end diastolic diameter >/= 5.5 cm; d. Preserved LV function ≥55% | |

| ☐ Mitral valve repair with Tricuspid valve repair | Remarks |
|--|---------|
| 1. Age up to 18 years and 364 days old | |
| 2. Mitral valve regurgitation criteria fulfilled as above a. Symptomatic with NYHA II -III; b. Vena contracta >0.7 cm, RF >50%; c. Left Ventricular end systolic diameter >/= 4; Or LVESD enlarged by z score; OR LV end diastolic diameter >/= 5.5 cm; d. Preserved LV function ≥55%. | |
| 3. Check concomitant Tricuspid Valve (if applicable) (Before or after repair on intraoperative echocardiogram) a. Moderate or Severe Tricuspid Valve Regurgitation b. Dilated Tricuspid valve annulus > 4.0 mm c. With or without RV dilatation | |

| ☐ Aortic valve replacement | Remarks |
|--|---------|
| 1. Age at least 15 years old | |
| 2. Check etiology: a. If rheumatic Controlled RF activity or at least 2 weeks anti inflammatory b. If with infective endocarditis with negative blood Culture or antibiotic for at least 2 weeks c. If with vegetation – require Infectious service clearance after antibiotic load | |
| 3.a. SEVERE AORTIC STENOSIS (AS) Stage C1 1. Asymptomatic 2. Aortic valve annulus < 1.0cm2 and 3. AV mean gradient >/=40mmHG 4. Left ventricular ejection fraction (LVEF)>50% | |
| 3.b. SEVERE AORTIC STENOSIS WITH REDUCED EJECTION FRACTION or Stage C2 Asymptomatic or at least NYHA Class II Aortic valve area <1.0mm2 gradient >/= 40mmhg Left ventricular ejection fraction (LVEF) < 50% classical low flow low gradient AS 3.c. SEVERE RHEUMATIC AORTIC REGURGITATION Symptomatic with at least NYHA II LVEF>55% Left Ventricular end systolic diameter >5.5 or LV end diastolic diameter > 7.0; OR enlarged LVESD or LVEDD by z score | |
| 4. With Approval of Valve team for a. Age <15 years old b. Vegetation with risk for embolization as above as urgent c. Symptomatic with NYHA III-IV d. With depressed LV function <55% but> 25% | |

| Aortic valve replacement with Tricuspid valve annuloplasty | Remarks |
|--|---------|
| 1. Aortic valve replacement criteria fulfilled as indicated above | |
| 2. If rheumatic etiology, check concomitant Tricuspid Valve Regurgitation (if applicable) a. Moderate or Severe Tricuspid Valve Regurgitation b. Dilated Tricuspid valve annulus > 4.0 mm c. With or without Right Ventricular (RV) dilatation | |

| Certified correct by: | | | | | | | | Conforme by: | | | | |
|-------------------------------------|--|---|--|---|--|--|-------------------------------|--------------|------|-----|---|--------------------------|
| | | | | | | | | | | | | |
| (Printed name and signature) | | | | | | | (Printed name and signature) | | | | | |
| Attending Pediatric Cardiologist or | | | | | | | 🗆 Patient 🗆 Parent 🗆 Guardian | | | | | |
| Cardiovascular Surgeon | | | | | | | | | | | | |
| PhilHealth Accreditation | | Т | | | | | | | | Τ | | Date signed (mm/dd/yyyy) |
| No. | | | | • | | | | | | ' | A | |
| Date signed (mm/dd/yyyy) | | | | | | | | | | | | |
| | | | | | | | | | 1 an | 100 | | |

Note:

Once approved, the contracted HF shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.

There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits Package for Heart Valve Repair and/or Replacement for Valvular Heart Disease. Please do not leave any item blank.

PRE-AUTHORIZATION REQUEST Z Benefits Package for Heart Valve Repair and/or Replacement for Valvular Heart Disease (Pediatric)

| £100 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| DATE OF REQUEST (mm/dd/yyyy): | | | | | | | | | |
| This is to request approval for provision of services under the Z Benefits Package for Valvular Heart Disease Repair and/or Replacement for | | | | | | | | | |
| (Patient's last, first, suffix, middle name) (Name of HF) | | | | | | | | | |
| under the terms and conditions as agreed for availment of the Benefit Package. | | | | | | | | | |
| The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box): | | | | | | | | | |
| Without co-payment With co-payment, for the purpose of: | | | | | | | | | |
| | | | | | | | | | |
| Certified correct by: Certified correct by: | | | | | | | | | |
| (Printed name and signature) Attending Cardiologist | (Printed name and signature) Attending Cardiovascular Surgeon | | | | | | | | |
| PhilHealth Accreditation No. PhilHealth - PhilHealth Accreditation - | | | | | | | | | |
| Conforme by: | Certified correct by: | | | | | | | | |
| (Printed name and signature) | (Printed name and signature) | | | | | | | | |
| □ Patient □ Parent □ Guardian | Executive Director/Chief of Hospital/ | | | | | | | | |
| T | Medical Director/ Medical Center Chief | | | | | | | | |
| PhilHealth Accreditati on No. | | | | | | | | | |
| (For PhilHealth Use Only) APPROVED DISAPPROVED (State reason/s) | | | | | | | | | |
| (Printed name and signature) | | | | | | | | | |

Head or authorized representative, Benefits Administration Section (BAS)

| INITIAL APPLICATION | | | COMPLIANCE TO REQUIREMENTS | | |
|---|---------|------|---|---------|------|
| Activity | Initial | Date | APPROVED | | |
| Received by LHIO/BAS: | | | DISAPPROVED (State reason/s) | | |
| Endorsed to BAS (if received by LHIO): | | | (Printed name and signature) Head or authorized BAS representative | | |
| Approved Disapproved | | | Activity | Initial | Date |
| Released to HF: | | | Received by BAS: | | |
| The pre-authorization shall be valid for one hundred eighty (180) calendar days from the date of approval of request. | | | Approved Disapproved Released to HF: | | |