Case No. _____

Annex "A – KT"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	*SEX* ☐ *Male* ☐ *Female*
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER (*answer only* if patient is a dependent)	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Fulfilled selections criteria ☐ **Yes** If yes, proceed to pre-authorization application
☐ **No** If no, specify reason/s and encode
_____

PRE-AUTHORIZATION CHECKLIST
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)

ATTESTED BY ATTENDING NEPHROLOGIST or TRANSPLANT SURGEON

Place a (✓) if YES

QUALIFICATIONS	YES
On chronic dialysis because of end stage renal disease except for pre-emptive kidney transplantation	
Anti-HCV negative	
Absence of current severe illness (congestive heart failure class 3-4), liver cirrhosis (findings of small liver with coarse granular/heterogeneous echo pattern with signs of portal hypertension), chronic lung disease requiring oxygen, etc.	
Absence of the following: hemiparalysis, mental incapacity such that informed consent cannot be made, and substance abuse for at least 6 months prior to start of transplant work-up.	

(Place a ✓if YES or NA if not applicable)

QUALIFICATIONS	YES
No previous history of cancer (except basal cell skin cancer).	
If patient is HIV-positive, the HIV-1 RNA viral load should be below detectable levels while on anti-retroviral therapy (<50 copies/mL) and CD4+ count should be >200 cells/mm^3;	

(Place a ✓if YES or NA if not applicable)

QUALIFICATIONS	YES
If the patient is HbsAg positive, all the following conditions must be met: *a. absence of liver cirrhosis*	
b. HBV- DNA <2,000 IU/ml	
c. cleared by a gastroenterologist, who is a member of the medical staff of the transplant facility *Clearance by the Gastroenterologist* _____ *Printed name and signature of Gastroenterologist* *PhilHealth accreditation no.* _____	
d. The patient is informed that if there shall be additional cost of other interventions, these shall be sourced from other financing sources. *"I was informed that if there shall be additional cost of other interventions, these shall be sourced from other financing sources; and I understand that I will require antiviral prophylaxis for as long as it is indicated."* *Conforme by:* _____ *Printed name and signature* ☐ *patient* ☐ *parent* ☐ *guardian*	
If the recipient is CMV IgG negative, any of the following should qualify: a. *Donor should be CMV IgG negative; OR*	
b. Recipient is CMV IgG negative and donor is CMV IgG positive: *"I understand that I will require CMV prophylaxis for as long as it is indicated and I am informed that I will be responsible for the additional cost of this medication and other interventions."* *Conforme by:* _____ *Printed name and signature* ☐ *patient* ☐ *parent* ☐ *guardian*	

(Tick appropriate box)

DIAGNOSTICS	
For pre-emptive kidney transplant and diabetic: 24-hour urine creatinine clearance or calculated glomerular filtration rate (GFR) (CKD-EPI formula) or nuclear GFR should be less than 20 mL/min /1.73m^2	☐ *Yes* ☐ *NA*
For pre-emptive kidney transplant and non-diabetic: 24-hour urine creatinine clearance or calculated glomerular filtration rate (GFR) (CKD-EPI formula) or nuclear GFR should be less than 15 mL/min /1.73m^2	☐ *Yes* ☐ *NA*
Low risk: a. Primary kidney transplant (no previous solid organ transplant)	☐ *Yes*
b. Single organ transplant	☐ *Yes*
c. Negative tissue crossmatch	☐ *Yes*
d. Historical Panel Reactive Antibody (PRA) Class 1 & 2 negative	☐ *Yes* ☐ *No. If no, answer e.1 and e.2*
e. If Historical Panel Reactive Antibody (PRA) Class 1 and/or 2 is positive, must fulfill the following: e.1 Historical PRA less than or equal to 20%	☐ *Yes*
e.2 No donor specific antibody (DSA) in the potential recipient	☐ *Yes*

Certified Correct by Attending Nephrologist or Transplant Surgeon:

_____

Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐

Note:
Once approved, the contracted HCI 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. Please do not leave any item blank.

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 441-7442 | Trunkline: (02) 441-7444
www.philhealth.gov.ph

PhilHealth@24: Tungo sa Kalusugan Para sa Lahat

PRE-AUTHORIZATION REQUEST
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)

DATE OF REQUEST (mm/dd/yyyy)

This is to request approval for provision of services under the Z benefit package for _____ (NAME OF PATIENT) in _____ (NAME OF HCI) under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient belongs to the following category (please tick appropriate box):

☐ No Balance Billing (NBB)
☐ Co-pay

Conforme by Patient/Parent/Guardian:	Certified correct by: (for Service Patients)
(Printed name and signature)	(Printed name and signature)
Certified correct by:	Please tick appropriate box ☐ Chair, Department of Adult Nephrology ☐ Chair, Dept. of Pediatric Nephrology ☐ Chair, Department of Organ Transplantation ☐ Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
(Printed name and signature) Attending Nephrologist	
PhilHealth Accreditation No.	PhilHealth Accreditation No.

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Authorized representative, Benefits Administration Section (BAS)

INITIAL APPLICATION			**COMPLIANCE TO REQUIREMENTS**		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to HCI:			Received by BAS:		
This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		