Annex A: Pre-authorization Checklist and Request Form

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No._____

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

(Place a ✓on the appropriate answer)

History of Previous Kidney Transplantation ☐ Not Applicable	
☐ Living Organ Donor: ☐ Related ☐ Non-Related	☐ Deceased Organ Donor
☐ Surgery (Date of Procedure (mm/dd/yyyy): _____ ☐ Left ☐ Right	

PRE-AUTHORIZATION CHECKLIST
Kidney Transplantation Procedure

(Place a ✓on the applicable procedure)

Type of Kidney Transplantation	Type of Immunosuppression	Type of Donor Nephrectomy
☐ Living Organ Donor ☐ Related ☐ Non-Related	☐ Basiliximab ☐ Rabbit anti-thymocyte globulin (rATG)	☐ Laparoscopic surgery for donor and open surgery for recipients ☐ Open surgery for both donor and recipients
☐ Deceased Organ Donor*		Type of Organ Preservation: ☐ Machine Perfusion ☐ Cold storage

*To be submitted within two (2) working days after completion of the surgery

(Place a ✓ on the appropriate answer; otherwise, indicate a remark as applicable)

Selection Criteria	**Remarks**
1.1. On chronic dialysis because of chronic kidney disease (CKD) stage 5	☐ Yes ☐ NA
1.2. For preemptive kidney transplantation ☐ Diabetic: 24-hour urine creatinine clearance or calculated glomerular filtration rate (GFR) (CKD-EPI formula) or nuclear	☐ Yes ☐ NA

Selection Criteria	Remarks
GFR should be less than 20 mL/min /1.73m2. ☐ 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 /1.73m2.	☐ Yes ☐ NA
2. Single organ transplant	☐ Yes
3. Negative T and B Cell Crossmatch	☐ Yes
4. History of kidney transplantation ☐ No (answer 4.1.a. and 4.1.b.) ☐ Yes (answer 4.2.a. and 4.2.b.)	
4.1.a. Historical Panel Reactive Antibody (PRA) Class 1 & 2 negative	☐ Yes ☐ NA
4.1.b. If Historical Panel Reactive Antibody (PRA) Class 1 and/or 2 is positive, must fulfill the following: i. Historical PRA less than or equal to 20% ii. No donor specific antibody (DSA) in the potential recipient	☐ Yes ☐ NA ☐ Yes ☐ Yes
4.2.a. PRA Screening <20% in both Class I and Class II 4.2.b. Absence of Donor Specific Antibodies (DSAs) by PRA Single Antigen Bead Assay	☐ Yes ☐ Yes
5. Absence of all of the following: a. Hemi-paralysis; b. Mental incapacity; and c. Substance abuse for at least 6 months prior to the start of transplant work-up.	☐ Yes
6. 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.	☐ Yes
7.1. History of cancer ☐ No ☐ Yes (answer 7.2)	
7.2. If with indolent and low-grade cancers after curative surgical/ablative treatment: ☐ Non-metastatic basal cell and squamous cell carcinoma of the skin, after complete removal ☐ Small renal cell carcinoma (< 3 cm), after radical nephrectomy ☐ Prostate cancer (Gleason score ≤ 6), after radical prostatectomy ☐ Thyroid cancer (Follicular/Papillary <2 cm, of low-grade histology), after total/subtotal thyroidectomy ☐ Breast ductal carcinoma in situ, after total mastectomy	☐ Yes ☐ NA

Selection Criteria	Remarks
Medical Clearance Date: _____ I, _____, oncologist, affiliated with _____, certifies that the patient's condition falls within the medical conditions specified under item 7.2 and can proceed to surgery. Oncologist: _____ Printed name and signature PhilHealth Accreditation No._____	
8.1. Hepatitis C Negative Recipient	☐ Yes ☐ No
8.2. If Hepatitis C Positive Recipient ☐ No liver cirrhosis ☐ Completed the treatment for 12 weeks with Direct Acting Antivirals (DAA) before the kidney transplantation; ☐ For recipients with deceased organ donors: On at least 4 weeks of DAA treatment before allocation of deceased donor kidney (and treatment should be continued for a total of 12 weeks post KT) Medical Clearance Date: _____ I, _____, gastroenterologist, affiliated with _____, certifies that the patient's condition falls within the medical conditions specified under item 8.2 and can proceed to surgery. Gastroenterologist: _____ Printed name and signature PhilHealth Accreditation No._____ Informed Consent Date: _____ I, _____, acknowledge and fully understand that I will be required to undergo antiviral prophylaxis for as long as it is medically prescribed. I have been informed that I will be personally responsible for any additional costs associated with this medication and other necessary interventions. Conforme by:_____ Printed name and signature ☐ Patient ☐ Parent ☐ Guardian	☐ Yes

Selection Criteria	Remarks
9.1. HIV-Negative	□ Yes □ No
9.2. HIV-Positive: HIV-1 RNA viral load below detectable levels while on antiretroviral therapy (<50 copies/mL) and CD4+ count should be >200 cells/mm3	□ Yes □ NA
10. 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 Medical Clearance Date: _____ I, _____, gastroenterologist, affiliated with _____, certifies that the patient's condition falls within the medical conditions specified under item 10 and can proceed to surgery. Gastroenterologist: _____ Printed name and signature PhilHealth Accreditation No._____ Informed Consent Date: _____ I, _____, acknowledge and fully understand that I will be required to undergo antiviral prophylaxis for as long as it is medically prescribed. I have been informed that I will be personally responsible for any additional costs associated with this medication and other necessary interventions. Conforme by:_____ Printed name and signature □ Patient □ Parent □ Guardian	□ Yes □ NA (If NA, proceed to Item No. 11.)
11. If the recipient is CMV IgG negative, any of the following should qualify: a. Donor is CMV IgG negative; OR b. Recipient is CMV IgG negative and donor is CMV IgG positive Informed Consent Date: _____ I, _____, acknowledge and fully understand that I will be required to undergo CMV prophylaxis for as long as it is medically prescribed. I have been informed that I will	□ Yes □ NA □ Yes □ NA

Selection Criteria	Remarks
be personally responsible for any additional costs associated with this medication and other necessary interventions. Conforme by:_____ Printed name and signature □ Patient □ Parent □ Guardian	

Certified correct by
Attending Nephrologist:

_____
Printed name and signature
PhilHealth Accreditation No.
□□□□–□□□□□□□–□

Certified correct by Attending
Transplant Surgeon:

_____
Printed name and signature
PhilHealth Accreditation No.
□□□□–□□□□□□□–□

Conforme by:

_____
Printed name and signature
□ Patient □ Parent □ Guardian

Date Signed (mm/dd/yyyy):

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. Please do not leave any item blank.

PRE-AUTHORIZATION REQUEST

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for _____ in _____
(Patient's last, first, suffix, middle name) (Name of HF)

under the terms and conditions as agreed for availment of the Z 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 Nephrologist	(Printed name and signature) Attending Transplant Surgeon
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:	Certified correct by:
(Printed name and signature) ☐ Patient ☐ Parent ☐ Guardian	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
	PhilHealth Accreditation 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 ☐ DISAPPROVED (State reason/s) _____ (Printed name and signature) Head or authorized BAS representative		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐Approved ☐Disapproved			**Activity**	**Initial**	**Date**
Released to HF:			Received by BAS:		
The pre-authorization shall be valid for sixty (60) calendar days			☐ Approved ☐Disapproved		
			Released to HF:		