Coverage of any medical intervention discussed in a Dean Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or summary plan description (SPD) and applicable state and/or federal laws.

Pancreas-Kidney (SPK, PAK) Transplantation MP9617

Covered Service: Yes

Prior Authorization Required: Yes

Additional Information: See Member Certificate or Summary Plan Description regarding services available for coverage.

For donor-derived cell-free DNA for kidney transplant rejection refer to Genetic Testing: Kidney Disorders MP9598.

For multiorgan transplant, the member must meet criteria for each organ. Please refer to applicable medical policy.

Medicare Policy: Prior authorization is dependent on the member's Medicare coverage. Prior authorization is not required for Dean Care Gold and Select when this service is provided by participating providers. If a member has Medicare primary and Dean Health Plan as secondary coverage, a prior authorization is required.

BadgerCare Plus Policy: Dean Health Plan covers when BadgerCare Plus also covers the benefit.

Dean Health Plan Medical Policy:

1.0 Pancreas-Kidney **Transplantation Evaluation requires** prior authorization through the Health Services Division and is considered medically necessary when documentation in the medical records indicates that the member meets **ALL** of the following criteria:

- 1.1 Member has labile insulin-dependent diabetes mellitus (IDDM); **AND**
- 1.2 Member also has **ANY** of the following diagnoses:
  - 1.2.1 End-Stage Renal Disease (ESRD) as defined by **ANY** of the following:
    - 1.2.1.1 Chronic kidney disease (CKD) with glomerular filtration rate (GFR) less than or equal to 20 ml/min/m^2
    - 1.2.1.2 Advanced chronic renal failure on dialysis
    - 1.2.1.3 Symptomatic uremia; **OR**
  - 1.2.2 Anticipated ESRD as defined in Section (1.2.1) within the next 12 months

2.0 Pancreas-Kidney **Transplantation requires** prior authorization through the Health Services Division and is considered medically necessary when documentation in the medical records indicates that the member meets **ALL** of the following criteria:

2.1 The member meets the institution's suitability criteria for transplant; **AND**

2.2 The member meets ALL of the criteria in Section (1.0)

3.0 Pancreas-Kidney **Retransplantation requires** prior authorization through the Health Services Division and is considered medically necessary when documentation in the medical records indicates that **ALL** of the following criteria are met:

3.1 Failed previous kidney/pancreas transplantation; **AND**

3.2 The criteria in Section (2.0) for initial transplantation must be met; **AND**

3.3 No history of behaviors since the previous transplant that would jeopardize a subsequent transplant

4.0 Islet cell transplants, except for autologous islet cell transplants associated with pancreatectomy, are considered **experimental and investigational**, and therefore not medically necessary.

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