HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

Beneficiary Full Name: _____ Sponsor's SSN: _____-_____-_____

Date of Birth: _____ Beneficiary State of Residence: _____

Dear Provider,

Please complete the letter of attestation below and return as indicated on the additional information letter or attach it to your online request.

TRICARE Policy Manual, Chapter 4, Section 9.1 authorizes coverage of ventricular assist devices (VADs), external and implantable, when the device is Food and Drug Administration (FDA) approved and used in accordance with FDA approved indications.

THE VAD IS NOT INTENDED FOR DESTINATION THERAPY

In order for a VAD to be approved when NOT intended for destination therapy, the provider must attest to the following:

☐ The VAD is FDA-approved and will be used in accordance with FDA-approved indications.

THE VAD IS INTENDED AS DESTINATION THERAPY

In order for a VAD to be approved when intended for destination therapy, the provider must attest to EACH of the following:

☐ The VAD has received approval from the FDA for destination therapy and will be used according to the FDA-approved labeling instructions.

☐ The VAD procedure will be performed at a TRICARE-certified heart transplantation center, a TRICARE-certified pediatric consortium heart transplantation center, or a Medicare facility which is approved for VAD implantation as destination therapy.

☐ The patient has chronic end-stage heart failure (New York Heart Association Class IV end-stage left ventricular failure for at least 90 days with a life expectancy of less than two years).

☐ The patient is not a candidate for heart transplantation.

☐ The patient's Class IV heart failure symptoms have failed to respond to optimal medical management, including a dietary salt restriction, diuretics, digitalis, beta blockers and ACE inhibitors (if tolerated) for at least 60 of the last 90 days.

☐ The patient has a left ventricular ejection fraction (LVEF) less than 25 percent.

☐ The patient has demonstrated functional limitation with a peak oxygen consumption of less than 12 ml/kg/min; or the patient has a continued need for intravenous inotropic therapy owing to symptomatic hypotension, decreasing renal function or worsening pulmonary congestion.

☐ The patient has the appropriate body size (by device per FDA labeling) to support VAD implantation.

I attest the information provided is true and accurate to the best of my knowledge. I understand Health Net Federal Services, LLC or designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Additional information: _____

Physician's printed name and title:_____

TIN: _____ Signature: _____ Date: _____

Authorizations and Referrals • PO Box 9108 • Virginia Beach, VA 23450-9108