OPTN

Public Comment Proposal

Establish Comprehensive Multi-Organ Allocation Policy

OPTN Ad Hoc Multi-Organ Transplantation Committee

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Establish Comprehensive Multi-Organ Allocation Policy

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Sponsoring Committee:	*Ad Hoc Multi-Organ Transplantation*
Public Comment Period:	*August 27, 2025-October 1, 2025*

Executive Summary

The proposal aims to promote equitable access to transplant among multi- and single-organ candidates and to facilitate consistent and efficient allocation. Currently, policy provides some direction on allocating multi-organ combinations, but it does not establish a comprehensive framework. Organ Procurement Organizations (OPOs) report varying allocation practices and note that multi-organ allocation can be resource-intensive and contribute to system inefficiencies. Current policy prioritizes multi-organ kidney candidates above single-organ kidney candidates, which impacts access for single-organ candidates, including highly-sensitized, medically urgent, and pediatric candidates.[1]

The MOT Committee has been working on policy to appropriately prioritize single- and multi-organ candidates since late 2022. Most recently, the Committee considered public comments in response to its *Request for Feedback: Establish Comprehensive Multi-Organ Allocation Policy*.[2] Participants supported standardizing multi-organ allocation and provided feedback which helped refine this proposal.

The proposal would standardize the allocation process and order of priority across different organ match runs for most deceased donors and highly prioritized candidate groups. The order of priority is set out in multi-organ allocation tables, which cover 98% of donors to multi-organ recipients and 78% of

[1] See, for example, S. Westphal et al, "The impact of multi-organ transplant allocation priority on waitlisted kidney transplant candidates," *American Journal of Transplant* 21, no. 6 (2021): 2161-2174, https://doi.org/10.1111/ajt.16390.

[2] *Request for Feedback: Establish Comprehensive Multi-Organ Allocation Policy*, OPTN Ad Hoc Multi-Organ Transplantation Committee, January 2025, https:// https://optn.transplant.hrsa.gov/media/xzkhg0v1/mot-jan-2025-public-comment_rff.pdf (last accessed June 24, 2025).

multi-organ recipients who received a transplant from these donors.[3] The tables incorporate the orders of priority in organ-specific policies, including lung composite allocation score (CAS) thresholds and the classification system for other organs. Prioritization decisions were based largely on medical urgency, as well as access to transplant and optimizing organ use. For donors not covered by a multi-organ allocation table, or if two or more organs remain unplaced after completion of the table, OPOs would decide the order in which they make offers across match runs. This approach standardizes allocation for most donors and high priority candidate groups and allows flexibility to place organs that are not usually donated to multi-organ recipients. Most of the proposed changes are to *OPTN Policy 5.10: Allocation of Multi-Organ Combinations,* though the proposal would also revise several other sections for consistency.

To promote equitable access to transplant among multi- and single- organ candidates, the Committee recommends removing priority for some multi-organ kidney candidates above all single-organ kidney candidates and requiring that offers be made to both single- and multi-organ candidates in the order they appear on the match runs, as directed by the multi-organ allocation tables. This proposal incorporates existing medical eligibility criteria for adult heart-kidney, liver-kidney, and lung-kidney candidates. There are currently no medical eligibility criteria for pediatric candidates or for adult candidates registered for other multi-organ combinations. To promote consistent allocation, the proposal would establish a binary "must"/"must not" offer framework for candidates registered for more than one organ and establish which organs follow the primary organ on each match run. OPOs would be required to run relevant match runs and a system-generated, donor specific multi-organ allocation plan prior to making offers to primary potential transplant recipients (PTRs).

To support implementation of complex multi-organ policy, the Committee requested development of a system-generated, donor specific multi-organ allocation plan to guide users through the multi-organ allocation tables. Additionally, the Committee supports pre-implementation training to help users transition and promote compliance. Strong post-implementation monitoring, comprising compliance and evaluation, will be critical to monitor impacts, including on pediatric candidates, organ use and utilization, and allocation out of sequence in the context of multi-organ allocation.

The Committee believes that the proposed changes would significantly improve the allocation system by promoting equitable access to transplant among multi- and single-organ candidates and facilitating consistent, transparent, and efficient allocation. The Committee looks forward to the community's feedback, generally, and on the questions in *Considerations for the Community*.

[3] OPTN Descriptive Data request, "Multi-Organ Transplant Recipients Not Covered by Proposed Allocation Tables Data Request." Prepared for MOT Committee Conference Call, March 26, 2025. The data request analyzed transplant data for multi-organ transplant recipients between 07/01/2023 and 06/30/2024.

Purpose

The proposal aims to promote equitable access to transplant among multi- and single-organ candidates and to facilitate consistent, transparent, and efficient allocation practices. The proposed policy would apply to most deceased donors with at least two different organs available for donation and would standardize the order in which OPOs make offers across different organ match runs for highly prioritized candidate groups. *Table 1* describes the ways in which the proposal aims to strengthen equity, consistency, transparency, and efficiency.

Table 1: How the proposal aims to strengthen equity, consistency, transparency, and efficiency

Equity	• Directs order of allocation across match runs based on medical urgency, access to transplant, and minimizing organ non-use • Promotes access to transplant for medically urgent, highly-sensitized, and pediatric single organ candidates by removing priority for some multi-organ candidates above all single organ candidates
Consistency and transparency	• Standardizes allocation processes from most deceased multi-organ donors and order of priority for high-priority candidate groups • Increases transparency and allows candidates to better understand priority • Facilitates stronger monitoring of outcomes, compliance, and allocation out of sequence in the context of multi-organ allocation
Efficiency	• Provides a system-generated, donor specific multi-organ allocation plan for most deceased donors • Updates match runs to display which additional organs must/must not be offered • Directs allocation order for donors most likely to donate to multi-organ candidates and high priority candidate groups and provides flexibility for other offers

Background

Currently, OPTN policy does not direct the order in which OPOs make offers across different organ-specific match runs. This contributes to differing allocation practices across the country. Current policy prioritizes multi-organ kidney candidates above single-organ kidney candidates, which impacts access for single-organ candidates, including highly-sensitized, medically urgent, and pediatric candidates.[4] Additionally, OPOs report directing significant resources to developing allocation plans for each donor.

Multi-organ transplantations have increased over the past two decades, from 522 in 2005 to 1,336 in 2024.[5] This increase underscores the importance of fair and consistent multi-organ allocation policy. In 2019, the OPTN Board of Directors endorsed a white paper, *Guidance on Multi-Organ Transplant Allocation Policy and Practice*, developed by the OPTN Ethics Committee. The white paper noted that multi-organ allocation policies may contribute to inequities in access to transplant among single- and multi-organ candidates and called for standardization of multi-organ policy across different organs that

[4] See, for example, Scott Westphal et al. The impact of multi-organ transplant allocation priority on waitlisted kidney transplant candidates. *American Journal of Transplant,* 21 (6), June 2021.

[5] OPTN national data as of June 15, 2025, https://optn.transplant.hrsa.gov/data/view-data-reports/national-data/ (accessed June 16, 2025). These data do not include kidney-pancreas or heart-lung transplants.

balances equity and utility.[6] The MOT Committee has been working on policy to appropriately prioritize single- and multi-organ candidates since late 2022. Initially, the MOT Committee's work focused on determining priority for kidneys among kidney-alone candidates and multi-organ candidates needing a kidney. Recognizing that the equity and efficiency challenges relating to kidney multi-organ policies also applied to other single-organ groups, the Committee expanded the scope of the project to address allocation priority among multi- and single-organ candidates more broadly.

The MOT Committee has received public feedback through OPTN public comment periods, open forum during their meetings, and general community feedback. Most recently, the Committee considered public comment in response to its *Request for Feedback: Establish Comprehensive Multi-Organ Allocation Policy*,[7] which set out proposed changes to the structure of multi-organ allocation. The request for feedback described the Committee's values prioritization exercise (VPE) and analysis of data on candidate waitlist mortality and outcomes, post-transplant survival, candidate access and time without an offer, and match run efficiency, which informed the prioritization of candidate groups across match runs. This data is shown in *Appendix 1: Allocation table for non-DCD multi-organ donors 18 to 69 years old with KDPI less than or equal to 34% showing key data points and rationale for placement.* Themes emerging from community feedback included:

- Support for standardizing multi-organ policy to promote fairness, consistency, and transparency
- Support for ensuring access to transplant for medically urgent, highly-sensitized, and pediatric candidates
- Acknowledgement of the complexity of the project
- Requests for a system solution that effectively and efficiently guides users through allocation
- Calls for pre-implementation training to promote compliance
- Calls for additional data and/or monitoring to strengthen understanding of potential impacts
- Advocacy for strong post-implementation monitoring, including assessing impacts on pediatric candidates, organ non-use, and potential adverse effects or unintended consequences

The Committee is grateful to the community for its feedback, which has helped refine this policy proposal.

[6] *OPTN Briefing Paper: Ethical Implications of Multi-Organ Transplants*, OPTN Ethics Committee, July 2019, https:// https://optn.transplant.hrsa.gov/media/2989/ethics_boardreport_201906.pdf (accessed June 24, 2025).

[7] *Request for Feedback: Establish Comprehensive Multi-Organ Allocation Policy*, OPTN Ad Hoc Multi-Organ Transplantation Committee, January 2025, https://https://optn.transplant.hrsa.gov/media/xzkhg0v1/mot-jan-2025-public-comment_rff.pdf (last accessed June 24, 2025).

Overview of Proposal

The proposed policy would apply to most donors with at least two different organs available for donation and would standardize the order in which OPOs make offers across different organ match runs for highly prioritized candidate groups. *Table 2* outlines the key differences between current and proposed multi-organ allocation policy. The components of the proposal are described below.

Table 2: Key differences between current and proposed multi-organ allocation policy

What are the key differences between current and proposed multi-organ allocation policy?	
Current	**Proposed**
Policy provides some direction in relation to allocating certain multi-organ combinations	Policy provides a holistic approach, focusing on equitable, consistent, and efficient allocation of organs from deceased multi-organ donors
Policy does not direct the order in which OPOs make offers across organ match runs	Policy would direct allocation order across match runs for donors and candidates covered by multi-organ allocation tables
Policy does not direct which additional organs follow the primary organ on each match run	Policy would direct which additional organs follow the primary organ on each match run
Policy gives some heart-kidney, liver-kidney, lung-kidney, and kidney-pancreas candidates priority over kidney-alone candidates	Policy would remove priority for these kidney-multi-organ candidates and require that offers be made to both single- and multi-organ candidates according to the multi-organ allocation tables
Policy includes several types of multi-organ offers such as required shares, permissible shares, and priority for some multi-organ candidates above single-organ candidates	Policy would incorporate a binary “must”/“must not” offer framework for additional organs for which candidates are registered

Removing priority for multi-organ candidates above high priority single organ candidates

Under current policy, some heart-kidney, liver-kidney, lung-kidney, and kidney-pancreas candidates receive priority above kidney-alone candidates. The proposal would remove this priority and require offers to both single- and multi-organ candidates according to the multi-organ allocation tables.

The MOT Committee considers this as the most equitable approach to allocation. It is expected to increase access to transplant for high priority single organ candidates, including medically urgent, highly-sensitized, and pediatric candidates. The proposed approach is consistent with current heart-lung, heart-liver, and lung-liver policies, which require offers to single- and multi-organ candidates in the order they appear on matches.

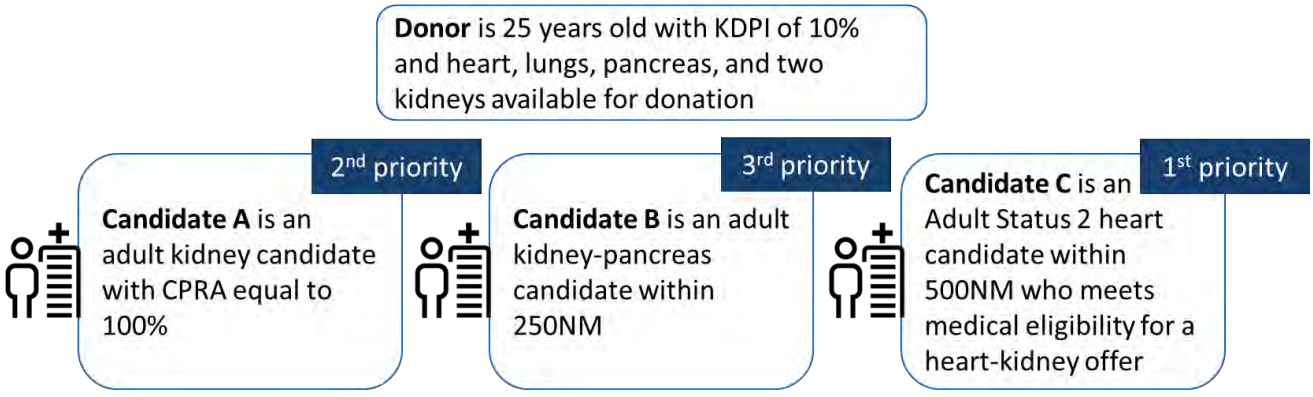
Figure 1 shows how the proposed policy would promote access to transplant for high priority single-organ candidates. In this example, Candidate C would receive highest priority for a kidney, Candidate A would receive second priority, and Candidate B would receive third priority. Candidate A, who is highly-sensitized and difficult to match with potential donors, has increased access to transplant as compared to current policy, under which both Candidate B and C would be prioritized over single-organ kidney candidates.

Promoting access to transplant for high priority single-organ candidates

In May 2024, an OPTN member participated in the open forum segment of the MOT Committee meeting and called for increased access to transplant for high-priority kidney candidates. The member described the case of a highly-sensitized pediatric kidney candidate at their program who missed an opportunity to receive a kidney offer. The kidney was accepted for a multi-organ candidate who was eligible for priority above single-organ kidney candidates. After the multi-organ transplant did not proceed, the kidney was offered to another candidate on the waiting list.

The member commented that this example underscores the importance of the MOT Committee's work to ensure that kidneys are available for single-organ kidney candidates, especially highly-sensitized, medically urgent, and pediatric candidates.

Figure 1: Example showing increased access to transplant for high priority single-organ candidates



Multi-organ offers and medical eligibility criteria

The proposed framework for multi-organ offers and medical eligibility criteria described below would apply to all multi-organ offers, including offers not covered by a multi-organ allocation table (see *Allocation order and process,* below).

Framework for multi-organ offers

The proposed policy would establish a binary "must offer" or "must not offer" framework for additional organs for which candidates are registered.

OPOs must offer additional organ(s) for which the candidate is registered when:

- The multi-organ combination may be made from the match run (see *Multi-organ offers by match run*, below); and
- The PTR meets medical eligibility criteria (see *Medical eligibility criteria,* below)

OPOs must not offer organs for which the PTR does not meet medical eligibility criteria.

OPOs must not offer a heart, lung, or liver from the intestine, kidney, or pancreas/kidney-pancreas match runs.

All multi-organ offers are subject to organ availability, meaning that if an organ has been accepted according to *OPTN Policy 5.6.D: Effect of Acceptance*, it is no longer available to be offered to other candidates, including multi-organ candidates.

OPOs must offer organ(s) a multi-organ candidate is eligible for, even if other organs they are registered for have already been accepted. For example, if a candidate is registered for and meets eligibility criteria for heart-liver-kidney, and the liver has already been accepted for another candidate, the OPO must offer the heart and kidney to the candidate.

This binary "must offer" or "must not offer" approach for additional organs differs from current policy, which includes several possible directions, such as required offers, permissible offers, and priority for some multi-organ candidates above single-organ candidates. The removal of permissible shares aims to promote consistent allocation. The removal of priority for some multi-organ candidates above single-organ candidates aims to promote equitable access to transplant by prioritizing single- and multi-organ candidates in the order in which they appear on match runs.

Multi-organ offers by match run

As part of the effort to standardize multi-organ allocation, the proposed policy would direct the match runs from which multi-organ offers can be made:

- On the heart and heart-lung match runs, all other organs may follow the heart/heart-lungs
- On the lung match run, all other organs may follow the lungs
- On the liver match run, all other organs may follow the liver
- On the intestine match run:
    - kidney, pancreas, and covered vascularized composite allografts (VCA) may follow the intestine
    - OPOs must not offer the heart, lungs, or liver from the intestine match run
- On the kidney match run:
    - intestine, and covered VCA may follow the kidney
    - OPOs must not offer the heart, lungs, or liver from the kidney match

- On the pancreas/kidney-pancreas match run:
    - intestine and covered VCA may follow the pancreas/kidney-pancreas
    - OPOs must not offer the heart, lung or liver from the pancreas/kidney pancreas match run

The Committee considered whether hearts, livers, and lungs should follow as additional organs on the intestine, kidney, or pancreas/kidney-pancreas match runs. It concluded that hearts, lungs, and livers should not follow on these match runs to preserve access to transplant for heart, lung, and liver candidates in classifications below the highest priority intestine, kidney, pancreas, or kidney-pancreas candidates. For example, if a kidney candidate with Calculated Panel Reactive Antibody (CPRA) equal to 100% was receiving a kidney offer from the kidney match, and was also registered for a heart, the Committee proposes that the heart not follow the kidney, so that it remains available for heart Adult Status 3 or Pediatric Status 1B within 250NM, who are lower in the multi-organ allocation tables.

Under the proposed policy, covered VCA[8] would follow on all match runs, however the Committee determined that hearts, lungs, livers, intestines, kidneys, and pancreata should not be offered from the VCA match run. Additionally, pancreas islets would not follow other organs, nor would other organs follow pancreas islets. Candidates registered for pancreas islets would continue to receive offers from the pancreas/kidney-pancreas match run.

Multi-organ medical eligibility criteria

As noted above, OPOs must make multi-organ offers to all PTRs who meet medical eligibility criteria. This policy incorporates the medical eligibility criteria for multi-organ offers in current OPTN policy.

There is no multi-organ medical eligibility criteria for pediatric candidates. Adult candidates registered for heart-kidney or lung-kidney (including those registered for additional organ(s)) must meet medical eligibility criteria in *Table 5-5: Medical Eligibility Criteria for Heart-Kidney and Lung-Kidney Allocation.* Adult candidates registered for liver-kidney (including those registered for additional organ(s)) must meet medical eligibility criteria in *Table 5-6: Medical Eligibility Criteria for Liver-Kidney Allocation.* Candidates registered for heart-liver-kidney or lung-liver-kidney may meet either medical eligibility criteria. There is no medical eligibility criteria for adult candidates registered for other multi-organ combinations, such as heart-lung, heart-liver, lung-liver, and liver-intestine.

[8] Covered VCA is defined in *OPTN Policy 1.2: Definitions.* An example of VCA following on primary organ match runs is abdominal wall following on the intestine match run.

Table 3 shows example PTRs and the organ offers they would receive according to the organ offer framework and multi-organ medical eligibility criteria set out in this policy proposal.

Table 3: Example PTRs and multi-organ offers

Match run	PTR	Medical eligibility criteria	Offer	Explanation
Liver	Adult liver-kidney	Does not meet liver-kidney criteria	Liver: must offer Kidney: must not offer	The OPO must not offer the kidney because the PTR does not meet liver-kidney medical eligibility criteria.
Liver	Adult heart-liver-kidney	Does meet liver-kidney criteria Does not meet heart-kidney criteria	Heart: must offer Liver: must offer Kidney: must offer	The OPO must offer the heart-liver-kidney because the PTR meets either the liver-kidney or heart-kidney medical eligibility criteria.
Heart	Pediatric heart-kidney	No medical eligibility criteria	Heart: must offer Kidney: must offer	There is no medical eligibility criteria for pediatric candidates. The OPO must offer the heart-kidney.
Intestine	Adult intestine-pancreas	No medical eligibility criteria	Intestine: must offer Pancreas must offer	There is no medical eligibility criteria for this combination. The OPO must offer the intestine-pancreas.
Kidney	Pediatric heart-kidney	No medical eligibility criteria	Heart: must not offer Kidney: must offer	The OPO must not offer the heart from the kidney match run.

The match runs would display whether OPOs must or must not offer additional organs for which the PTR is registered. *Figure 2* shows example liver and kidney match runs. When a PTR is registered for more than one organ, the additional organ(s) column would show whether the OPO must or must not offer them along with the primary organ. If there are no organs shown in the additional organ(s) column, the candidate is a single organ candidate.

On the example liver match, the OPO would be required to make the following offers:

- Sequence 9: Must offer liver, heart, and kidney
- Sequence 10: Must offer liver
- Sequence 11: Must offer liver; must not offer kidney

On the example kidney match, the OPO would be required to make the following offers:

- Sequence 15: Must offer kidney; must not offer heart
- Sequence 16: Must offer kidney
- Sequence 17: Must offer kidney

Figure 2: Example match runs showing must/must not offer framework for additional organs

Liver match

Seq#	Center	Name	....	Additional Organs		Offer response
				Must offer	Must not offer	
9	FXRX - TX1	Last name, First name		HR, KI		
10	FXRX - TX1	Last name, First name				
11	UXRX - TX1	Last name, First name			KI	

Kidney match

Seq#	Center	Name	....	Additional Organs		Offer response
				Must offer	Must not offer	
15	GXRX - TX1	Last name, First name			HR	
16	FXRX - TX1	Last name, First name				
17	UXRX - TX1	Last name, First name				

Additionally, OPOs would document the acceptance of any additional organs on the primary match. For example, on the liver match shown above, if the PTR at sequence 9 accepted the liver, heart, and kidney, the OPO would document acceptance of all three organs on the liver match. Currently, OPOs only document acceptance of the primary organ on a given match run. This change would facilitate stronger monitoring of outcomes, compliance, and allocation out of sequence in the context of multi-organ allocation as described in *Post-Implementation Monitoring,* below.

Allocation order and process

The proposed policy would apply to most deceased donors with at least two different organs available for donation and would standardize the allocation process and the order of priority for highly prioritized candidate groups.

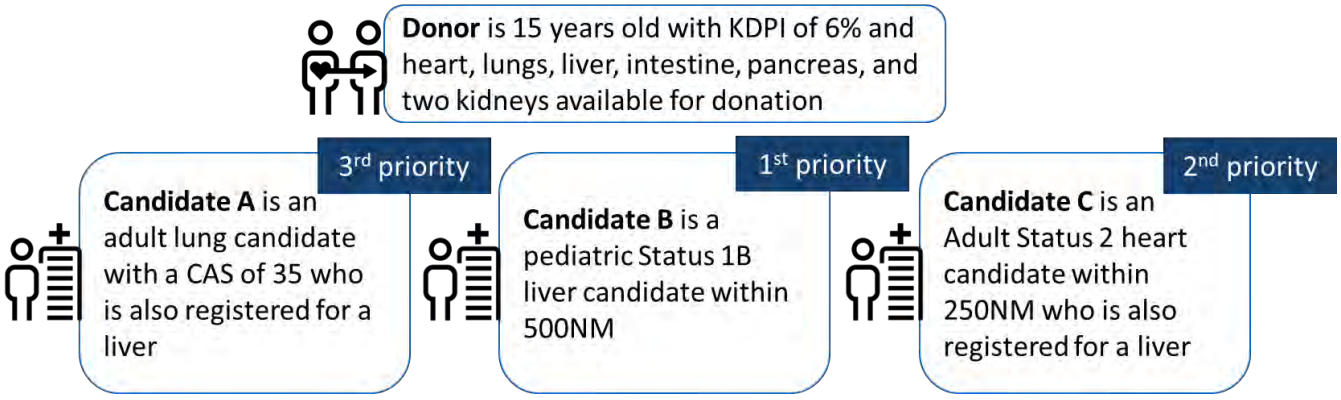
Allocation order

Proposed *Policy 5.10.A: Allocation Order* states that OPOs must allocate organs from deceased multi-organ donors according to the multi-organ allocation tables. More information on the donors and candidates covered by multi-organ allocation tables is provided below in *Covered donors* and *Multi-organ allocation tables.*

For deceased donors not covered by a multi-organ allocation table or if all organs have not been accepted upon completion of the multi-organ allocation table, OPOs may determine the order in which to make organ offers across match runs. This approach for offers not covered by a multi-organ allocation table is consistent with current policy and practice.

Figure 3 shows how the proposed policy would standardize allocation to ensure that organs are offered to the highest priority candidates across different organ match runs. In this example, under the proposed policy, Candidate B would receive highest priority for the liver, Candidate C would receive second priority, and Candidate A would receive third priority. Currently, policy does not direct the order in which OPOs make offers across match runs, so which candidate received an offer for the liver would depend on whether the OPO was offering from the lung, liver, or heart match run.

Figure 3: Example showing impacts of standardizing allocation order across match runs



Allocation process

Proposed *Policy 5.10.B: Allocation Process* sets out the process that OPOs must follow for deceased multi-organ donors:

- OPOs must determine which organs may be recovered and execute match runs for organs recovered for the purpose of transplantation[9]
- Prior to making organ offers to primary PTRs, OPOs must generate a multi-organ allocation plan; OPOs must make organ offers according to the multi-organ allocation plan

[9] This section includes specific requirements on running match runs for donors with certain organs available for donation (heart and lungs, liver and intestine, kidney(s) and pancreas). These requirements are consistent with current practice.

- If the OPO has made organ offers to all PTRs covered by a multi-organ allocation table, and organ(s) have not been accepted, the OPO may determine the order in which to make organ offers across match runs. This approach for offers not covered by a multi-organ allocation table is consistent with current policy and practice.
- If an organ becomes eligible for allocation according to *Policy 5.9: Released Organs, Policy 9.10: Expedited Placement of Livers,* or *Policy 11.6: Facilitated Pancreas Allocation*, OPOs may allocate the eligible organ according to these policies and must continue allocating other organs according to the multi-organ allocation table.

The requirement to generate a multi-organ allocation plan prior to making organ offers to primary PTRs serves several purposes. It allows some flexibility for OPOs to send out electronic notifications and take other preparatory steps, such as sending blood samples for crossmatching, prior to generating an allocation plan. It establishes a point in time by which OPOs must generate an allocation plan: before making organ offers to primary PTRs, which upon acceptance, are binding according to *Policy 5.6.D: Effect of Acceptance*. This point in time helps ensure consistent multi-organ allocation practices and facilitates compliance and outcomes monitoring. Note that, per *Table 4-1 Deceased Donor HLA Typing Requirements*, HLA typing on deceased kidney, kidney-pancreas, or pancreas donors would need to be reported prior to generating an allocation plan and making offers to primary PTRs.

Proposed *Policy 5.10.C: Re-executing Multi-Organ Allocation Plans* addresses circumstances in which a match run is re-executed after the OPO has made an organ offer to a primary PTR. For example, a match would need to be re-executed if a donor converted from donation after circulatory death (DCD) to brain death.[10] If a match is re-executed after the OPO has made an organ offer to a primary PTR, the proposed policy would require the OPO to re-execute the multi-organ allocation plan and make offers according to the new plan.

Proposed *Policy 5.10.C* also addresses circumstances in which an organ becomes available for donation after the OPO has made an organ offer to a primary PTR, for example, if the donor's lungs were not initially deemed as suitable for donation, but subsequently improved. If an organ becomes available for donation after the OPO has made an organ offer to a PTR, the proposed policy would require the OPO to execute the match for the additional organ, re-execute the multi-organ allocation plan, and make subsequent offers according to the new plan. In accordance with *Policy 5.6.D Effect of Acceptance*, organs previously accepted would remain with the PTR for whom it has been accepted.

To help understand the impacts of the proposed changes on multi-organ allocation processes, the MOT Committee considered median appearance data, which indicate how frequently registrations appear, on average, on a donor match run, whether or not the registration was extended an offer.[11,12] For example, 0 median appearances means that, on average, 0 registrations appeared in that classification across

[10] See OPTN Policy 2.15.I, *DCD Potential Donor Who Converts to Brain Death after an Organ Offer Has Been Made* (last accessed June 24, 2025).

[11] OPTN Descriptive Data Request, "Efficiency/Small Populations Data Request." Prepared for the MOT Committee Conference Call on May 14, 2025. The data request analyzed heart, heart-lung appearing on heart match, liver, liver-intestine, kidney and kidney-pancreas/pancreas match runs executed for deceased donors between 02/01/2023 and 12/31/2023.

[12] OPTN Descriptive Data Request, "Lung Multi-Organ CAS Thresholds and Heart-Lung Waiting List Mortality Data Request." Prepared for the Lung-MOT Workgroup Conference Call on May 13, 2025. The data request analyzed lung and heart-lung appearing on lung match runs executed for deceased donors between 09/28/2023 and 08/31/2024. Median appearance data for each multi-organ allocation table is provided in *Appendix 2: Multi-organ allocation tables showing median appearances.*

historic match runs. The measure provides a sense of the volume of registrations that would have historically been captured in the candidate groups included in the allocation tables. These data provide information on how many offers OPOs may have to make to complete the multi-organ allocation plan. The median appearance data for each multi-organ allocation table is provided in *Appendix 2: Multi-organ allocation tables showing median appearances.*

Most candidate groups[13] included in the multi-organ allocation tables have 0 median appearances. For example, in the allocation table for donation after brain death (DBD) adult donors with Kidney Donor Profile Index (KDPI) of 0-34%, 31 of the 55 candidate groups had 0 median appearances, 18 groups (plus the 3 Lung CAS categories for non-O donors) had 1-5 median appearances, 3 groups had 6-10 median appearances, and 3 groups had more than 10 appearances .[14] The number of median appearances tended to be similar across all seven multi-organ allocation tables. In the tables for DCD donors, the number of median appearances tended to be higher for liver classifications, with Liver Classifications 10 and 11 in each table having more than 100 median appearances.[15] This observation is likely because liver allocation policy provides for offers to larger groups of candidates for DCD donors as compared to DBD donors.

Given that the number of median appearances is low for the majority of candidate groups, the MOT Committee believes that the tables appropriately balance standardizing allocation order for high priority candidate groups across organ types, while ensuring that the number of offers required is not overly burdensome and promotes efficiency in allocation.

[13] "Candidate groups" refers to the lung CAS thresholds and classifications for other organ types.

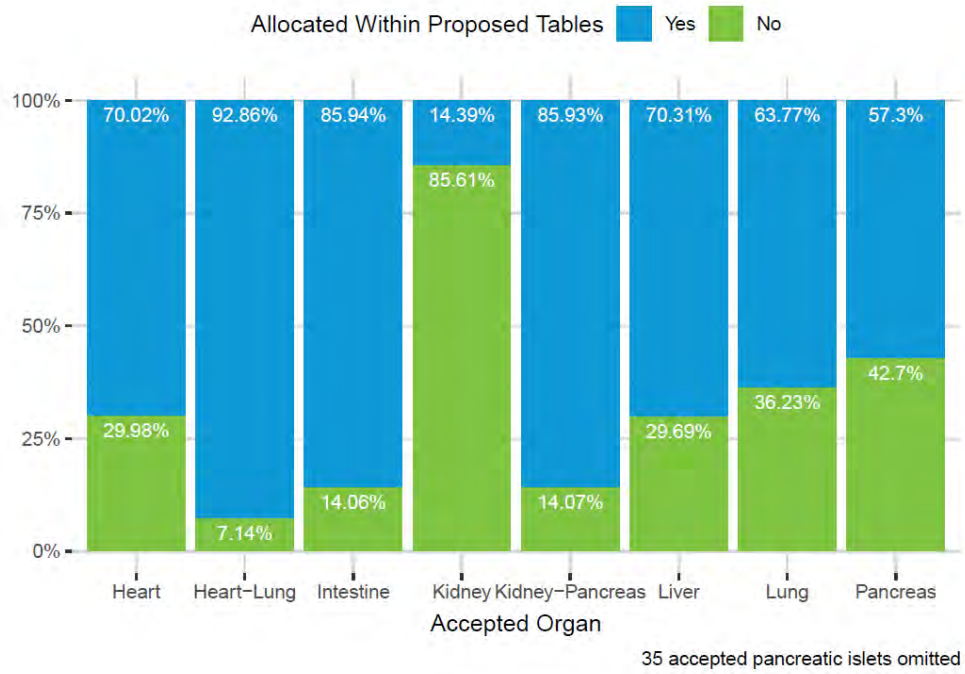
[14] Note that the lung CAS thresholds differ by donor blood type, with O donors generally having higher median appearances than non-O donors.

[15] See Allocation table for DCD multi-organ donors 18 to 69 years old with KDPI less than or equal to 34% showing median appearances and Allocation table for DCD multi-organ donors 18 to 69 years old with KDPI of 35%-85% showing median appearances in *Appendix 2*: *Multi-organ allocation tables showing median appearances.*

Additionally, the Committee analyzed data on match runs for all organs recovered from deceased donors and considered how frequently organs would remain unplaced upon completion of offers according to the relevant multi-organ allocation table. The data show that there were 58,503 deceased donor match runs in 2024. Of these, 47,336 (80.91%) would have been covered by the proposed multi-organ allocation tables. Additionally, the data show that for 11.18% of donors, all organs would be accepted before the multi-organ allocations table were exhausted. The allocation tables would completely cover all matches run for less than 1% of donors, meaning that at least one organ would remain unplaced upon completion of the allocation plan for 99% of deceased donors. *Figure 4* shows the percentage of organs that would be allocated within the proposed multi-organ allocation tables. Heart-lungs had the highest percent (92.86%) of organs accepted before the end of the proposed allocation table, while kidneys were least likely to be accepted before the end of the proposed allocation table (14.39%).[16]

In summary, the policy proposal would impact a large proportion of donors and matches, but it would fully direct allocation for the donor very rarely. Typically, 2-3 organs would remain unplaced upon completion of the allocation table and OPOs would allocate these organs according to the individual organ match runs. This is consistent with the Committee's intent to standardize allocation for most donors and high priority candidate groups and maintain flexibility to place organs that are not usually donated to multi-organ recipients.

Figure 4: Percent of accepted organs allocated within the proposed multi-organ allocation tables for deceased donors with match runs in 2024 by organ



[16] OPTN Descriptive Data Request, "Impact of Proposed Multi-Organ Allocation Tables on Match Run Data Request." Prepared for the MOT Committee Conference Call on April 4, 2025. The data request analyzed all match runs executed for deceased donors between 01/01/2024 and 12/31/2024.

Informed by the data requests, *Figure 5* provides an example of how allocation may occur, based on the allocation table for DBD adult donors with KDPI of 0-34% and five organs available for donation: heart, liver, pancreas, and two kidneys. As indicated by the icons, in this example, the heart and one kidney are accepted by an Adult Status 2 heart-kidney candidate, the liver is accepted by a liver-alone candidate with a MELD of at least 33, and one kidney and the pancreas remain available after all offers have been made according to the multi-organ allocation table.

Figure 5: Example allocation using allocation table for DBD adult donors with KDPI of 0-34% and 5 organs available for donation

Order	Organ classification and description	Order (cont.)	Organ classification and description (cont.)
1	Liver Class 1: Status 1A (adult and pediatric); 500NM	29	Pancreas or K/P Class 1: 0-ABDR mismatch; CPRA ≥ 80%; 250NM
2	Heart Class 1: Adult Status 1 or Pediatric Status 1A; 500NM	30	Pancreas or K/P Class 2: CPRA ≥ 80%; 250NM
3	Heart Class 2: Adult Status 1 or Pediatric Status 1A; 500NM	31	Heart Class 5: Adult Status 3 or Pediatric Status 1B; 250NM
4	Liver Class 2: Status 1B; 500NM	32	Heart Class 6: Adult Status 3 or Pediatric Status 1B; 250NM
5	Liver Class 3: Status 1A; HI or PR	33	Pancreas or K/P Class 3: 0-ABDR mismatch; CPRA ≥ 80%; nation
6	Liver Class 4: Status 1B; HI or PR	34	Pancreas or K/P Classification 4: 250NM
7	Lung CAS: 41 for O blood type donors; 37 for non-O donors	35	Kidney Class 6: Registered prior to 18 years old; 250NM
8	Heart Class 3: Adult Status 2; 500NM	36	Kidney Class 7: Medically Urgent; 250NM
9	Heart Class 4: Adult Status 2; 500NM	37	Kidney Class 8: 0-ABDR mismatch; CPRA equal to 99%; 250NM
10	Lung CAS: 35 for O blood type donors; 31 for non-O donors	38	Kidney Class 9: CPRA equal to 99%; 250NM
11	Kidney Class 1: 0-ABDR mismatch; CPRA = 100%; 250NM	39	Kidney Class 10: 0-ABDR mismatch; CPRA equal to 98%; 250NM
12	Kidney Class 2: CPRA equal to 100%; 250NM	40	Kidney Class 11: CPRA equal to 98%; 250NM
13	Kidney Class 3: 0-ABDR mismatch; CPRA = 100%; nation	41	Liver Class 13: MELD/PELD of at least 33; 150NM
14	Kidney Class 4: CPRA equal to 100%; nation	42	Liver Class 14: MELD/PELD of at least 33; 150NM
15	Kidney Class 5: Prior living donor; 250NM	43	Liver Class 15: MELD/PELD of at least 33; 250NM
16	Liver Class 5: MELD/PELD of at least 37; 150NM	44	Liver Class 16: MELD/PELD of at least 33; 250NM
17	Liver Class 6: MELD/PELD of at least 37; 150 NM	45	Liver Class 17: MELD/PELD of at least 33; 500NM
18	Liver Class 7: MELD/PELD of at least 37; 250NM	46	Liver Class 18: MELD/PELD of at least 33; 500NM
19	Liver Class 8: MELD/PELD of at least 37; 250NM	47	Liver Class 19: MELD/PELD of at least 30; 150NM
20	Liver Class 9: MELD/PELD of at least 37; 500NM	48	Liver Class 20: MELD/PELD of at least 29; 150NM
21	Liver Class 10: MELD/PELD of at least 37; 500NM	49	Liver Class 21: MELD/PELD of at least 29; 150NM
22	Liver Class 11: MELD/PELD of at least 37; HI or PR	50	Liver Class 22: MELD/PELD of at least 30; 250NM
23	Liver Class 12: MELD/PELD of at least 37; HI or PR	51	Liver Class 23: MELD/PELD of at least 29; 250NM
24	Intestine Class 1: Status 1; 500NM	52	Liver Class 24: MELD/PELD of at least 29; 250NM
25	Intestine Class 2: Status 1; 500NM	53	Liver Class 25: MELD/PELD of at least 30; 500NM
26	Intestine Class 3: Status 1; nation	54	Liver Class 26: MELD/PELD of at least 29; 500NM
27	Intestine Class 4: Status 1; nation	55	Liver Class 27: MELD/PELD of at least 29; 500NM
28	Lung CAS: 34 for O blood type donors; 30 for non-O donors		Organs remaining unplaced upon completion

Covered donors

The MOT Committee considered 12 potential donor groups and selected seven for inclusion in the multi-organ allocation tables. The seven donor groups, summarized in *Table 4,* were selected because they cover approximately 98% of multi-organ recipients between July 1, 2023-June 30, 2024. Some DCD donors were included because acceptance of DCD organs is increasing, and some pediatric donors with livers and intestines were included to promote access to multivisceral transplants (MVT) for pediatric patients. Most transplants from donors not covered by a multi-organ allocation table were from donors who had KDPI greater than 85% (1.11%) or who were DCD, less than 18 years old, with KDPI 0-84% (1.06%).[17]

Importantly, the Committee acknowledges the importance of the gift of life from *all* organ donors, whether or not they are included in the multi-organ allocation tables. While the tables focus on donors that typically donate to multi-organ recipients, donors that are not covered by multi-organ allocation tables would still be able to donate multiple organs to both single- and multi-organ candidates.

Table 4: Seven multi-organ donor groups covered by a multi-organ allocation table

Donor group	% of multi-organ recipients	Comments
DBD donors aged 18-69 with KDPI of 0-34%	55.75%	Highest percentage of donations to multi-organ recipients
DBD donors aged 18-69 with KDPI of 35-85%	19.29%	Second highest percentage of donations to multi-organ recipients
DCD donors aged 18+ with KDPI of 0-34%	6.23%	Likely growing percentage of donations to multi-organ recipients
DCD donors aged 18+ with KDPI of 35-85%	5.40%	Likely growing percentage of donations to multi-organ recipients
DBD donors aged 11-17 with KDPI of 0-34%	8.40%	Third highest percentage of donations to multi-organ recipients
DBD donors aged <11 with KDPI of 0-34% and liver and intestine available	1.02%	Important donor group for pediatric multivisceral candidates
DBD donors aged <11 with KDPI of 35-85% and liver and intestine available	1.48%	Important donor group for pediatric multivisceral candidates
Total	**97.57%**	

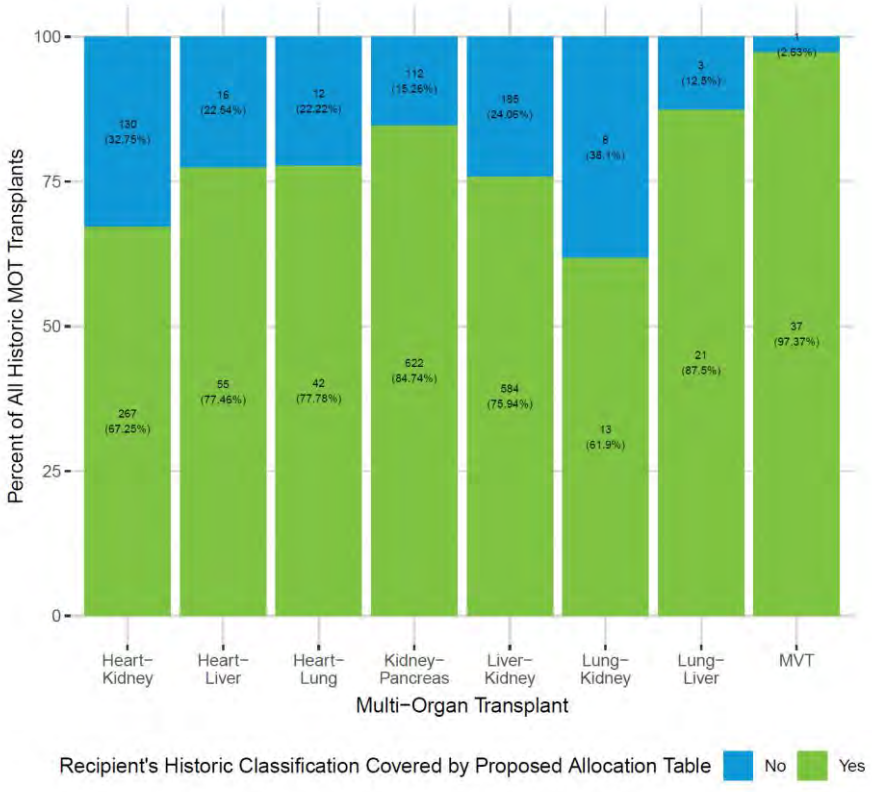
[17] OPTN Descriptive Data request, "Multi-Organ Transplant Recipients Not Covered by Proposed Allocation Tables Data Request." Prepared for MOT Committee Conference Call, March 26, 2025. The data request analyzed transplant data for multi-organ transplant recipients between 07/01/2023 and 06/30/2024.

Covered candidates

Overall, the proposed multi-organ allocation tables would cover 77.8% of multi-organ recipients who received a transplant from covered MOT donors. As shown in *Figure 6,* the proportion of recipients covered by a multi-organ allocation table varies between 62%-97% depending on the MOT combination. MVT recipients had the highest proportion of coverage, whereas lung-kidney and heart-kidney recipients had the lowest proportion of coverage.[18]

After analyzing the data described in this section and *Allocation process,* above, the Committee considered whether additional classifications should be added to cover more candidates and/or place more organs within the allocation tables. The MOT Committee has sought to standardize allocation order for high priority candidate groups and allow more flexibility for OPOs if organs remain available after completion of offers to candidates covered by multi-organ allocation tables. The Committee intentionally limited the number of candidate groups included in the tables so that working through the multi-organ allocation tables would not be overly burdensome for OPOs. Ultimately, the Committee concluded that the classifications and lung CAS thresholds included in the tables cover appropriate high priority candidates across different organ groups.

Figure 6: Percent of multi-organ recipients who received a transplant from MOT donors included in the multi-organ allocation tables



[18] OPTN Descriptive Data request, "Multi-Organ Transplant Recipients Not Covered by Proposed Allocation Tables Data Request." Prepared for MOT Committee Conference Call, March 26, 2025. The data request analyzed transplant data for multi-organ transplant recipients between 07/01/2023 and 06/30/2024.

Multi-organ allocation tables

For each group of donors above, the Committee developed multi-organ allocation tables, which direct the order of allocation of organs across match runs. The MOT Committee focused its initial working on developing an allocation table for DBD donors aged 18-69 with KDPI of 0-34%, as this group has the highest percentage of donations to multi-organ recipients. The proposed allocation table for this group is in proposed *Policy 5.10.F: Allocation of organs from non-DCD multi-organ donors 18 to 69 years old with KDPI less than or equal to 34%.* Informed by the data and VPE results, the MOT Committee recommends inclusion of 52 organ classifications and three lung CAS thresholds in this allocation table.

The Committee used the table for DBD donors aged 18-69 with KDPI 0-34% as its starting point for the other six multi-organ allocation tables. The Committee adjusted the tables for the other donor groups based on organ-specific allocation policies, which prioritize allocation differently depending on donor characteristics. For example, kidneys from donors with higher KDPI scores are allocated differently than donors with lower KDPI scores and hearts from adult donors are allocated differently than pediatric donors. The Committee also made some adjustments to prioritize some candidate groups in the context of specific donors. For example, the Committee prioritized pediatric candidates in the context of younger pediatric donors who may need access to smaller organs, and it prioritized medically urgent kidney candidates in the context of donors with higher KDPI. The tables include approximately 50 high priority candidate groups across all organ types, but each table length differs slightly, based on the underlying organ-specific policies and the Committee's prioritization decisions.

It is important to note that the multi-organ allocation tables incorporate the orders of priority established in organ-specific policies. The proposal does not change the orders of priority established by other OPTN Committees. For example, the allocation table for DBD donors aged 18-69 with KDPI of 0-34% incorporates the orders of priority from the following policies:

- Liver Classifications are from *OPTN Policy Table 9-11: Allocation of Livers from Non-DCD Deceased Donors at Least 18 Years Old and Less than 70 Years Old*
- Heart Classifications are from *OPTN Policy Table 6-7: Allocation of Hearts from Deceased Donors At Least 18 Years Old*
- Lung Composite Allocation Score ranges are based on *OPTN Policy 10.1: Lung Composite Allocation Score*
- Kidney Classifications are from *OPTN Policy Table 8-7: Allocation of Kidneys from Deceased Donors with KDPI Less Than or Equal To 20%* and *OPTN Policy Table 8-8: Allocation of Kidneys from Deceased Donors with KDPI Scores Greater Than 20% but Less Than 35%*
- Intestine Classifications are from *OPTN Policy Table 7-1: Allocation of Intestines*
- Pancreas and Kidney-Pancreas Classifications in this table are from *OPTN Policy Table 11-5: Allocation of Kidneys and Pancreas from Deceased Donors 50 Years Old and Less with a BMI Less Than or Equal To 30 kg/m2* and *OPTN Policy Table 11-6: Allocation of Kidneys and Pancreas from Deceased Donors More Than 50 Years Old or with a BMI Greater Than 30 kg/m2*

Order of priority

Determining the order of priority among different organ groups is complex and challenging work. The MOT Committee's approach included a VPE and analysis of data on candidate waitlist mortality and outcomes, post-transplant survival, candidate access and time without an offer, match run efficiency, and median appearances. This data is shown in *Appendix 1: Allocation table for non-DCD multi-organ donors 18 to 69 years old with KDPI less than or equal to 34% showing key data points and rational for placement.*

Prioritization decisions were based largely on medical urgency, considering access to life-sustaining technologies. For example, the Committee recommends that Liver Classification 1 candidates (Status 1A within 500NM) receive the highest priority because they are not expected to survive more than seven days without transplant, and they do not have access to life-sustaining technologies. The Committee considered placing Heart Classification 1-2 candidates (Adult Status 1 and Pediatric Status 1A within 500NM) above Liver Classification 1 candidates, but decided to prioritize liver candidates above heart candidates, because heart candidates have access to life-sustaining technologies.

While medical urgency is the main factor driving the Committee's prioritization decisions, some candidate groups are prioritized to promote access to transplantation and to avoid organ non-utilization. For example, the Committee recommends that highly-sensitized kidney candidates in Classifications 1-4 (CPRA[19] equal to 100%, nation) are placed directly below the most medically urgent liver, heart, and lung candidates. Although they may not be as medically urgent based on estimated waitlist survival, the Committee recommends that they receive high priority because suitable organs for highly-sensitized candidates are exceedingly rare. Similarly, although Kidney Classification 5 candidates (prior living donors within 250NM) may not be medically urgent, the Committee recommends giving them high priority to honor and promote the gift of life.

The median appearance data, described in *Allocation process,* above, provides information on how often candidates are likely to appear in each classification, which helps assess the impact of prioritizing certain candidate groups above others. For example, since highly-sensitized kidney candidates in Kidney Classifications 1-4 (CPRA equal to 100%, nation) and Kidney Classification 5 (prior living donors within 250NM) have 0 median appearances, giving them high priority is not likely to significantly impact access to transplant for classifications appearing below.

In its Winter 2025 request for feedback, the Committee released six of the seven multi-organ allocation tables for public comment. Since that time, the Committee developed a seventh table for DCD adult donors with KDPI of 35-85%, reflecting the increase in multi-organ donations from DCD donors generally, and this group specifically. Additionally, the Committee made some minor revisions to the other tables.

During the Winter 2025 public comment cycle, the community was generally supportive of the candidate groups included in the multi-organ allocation tables. An area of diverging opinions was whether pancreas/kidney-pancreas candidates or pediatric kidney candidates should be given higher priority in the table for DBD donors aged 11-17 with KDPI of 0-34%. The OPTN Pancreas Committee noted that under current policy, kidney-pancreas candidates in Classifications 1-4 receive priority over kidney-alone candidates, and expressed concern that prioritizing Kidney Classification 6 (pediatric) candidates above Kidney-Pancreas Classification 4 candidates would negatively impact pancreas allocation from this important donor group. The OPTN Pediatric Committee called for priority for Kidney Classification 6 (pediatric) candidates above all kidney-pancreas candidates, citing the risk of missed transplant opportunities for pediatric patients, particularly given frequent late declines among kidney-pancreas recipients.

The MOT Committee recognizes the competing imperatives of access to transplant for pediatric kidney candidates and for kidney-pancreas candidates, which is an important part of minimizing non-utilization of pancreata. The MOT Committee had recommended placement of Kidney Classification 6 above

[19] Calculated Panel Reactive Antibody.

Kidney-Pancreas (K/P) Classification 4 for this donor group. In response to public feedback, the Committee reviewed the median appearance data, which is shown in *Table 5,* below. The data show that on average, there would be no candidates in Pancreas/Kidney-Pancreas Classifications 1-3, three candidates in Kidney Classification 6, and 28 in Pancreas/Kidney-Pancreas Classification 4. Based on this data, the MOT Committee agreed that its recommended order of priority appropriately balances access to transplant among pediatric candidates and kidney-pancreas candidates.

Table 5: MOT Committee's recommended placement of pancreas/kidney-pancreas and pediatric kidney classifications in the table for DBD donors aged 11-17 with KDPI of 0-34% showing median appearance data and interquartile range (IQR)

Organ classification and description	Median appearances
Pancreas or K/P 1: 0-ABDR mismatch; CPRA ≥ 80%; 250NM	0
Pancreas or K/P 2: CPRA ≥ 80%; 250NM	0
Pancreas or K/P 3: 0-ABDR mismatch; CPRA ≥ 80%; nation	0
Kidney 6: Registered prior to 18 years old; 250NM	3
Pancreas or K/P 4: 250NM	28

Lung CAS thresholds

Lungs are the only organs currently allocated through a continuous distribution system, which means that lung candidates are assigned a composite allocation score along a continuous scale instead of grouped into classifications for allocation. The Committee established a Lung Multi-Organ Workgroup (the Workgroup) to identify lung CAS thresholds to capture a subset of lung candidates to include in the multi-organ allocation tables between the classifications for other organ types. The Committee adopted the Workgroup's recommendations and proposes incorporating three lung CAS thresholds into the tables: (1) a very high threshold to capture the most medically urgent lung multi-organ candidates; (2) a high threshold, to capture other medically urgent lung multi-organ candidates; and (3) a lower threshold to facilitate access to transplant for other lung multi-organ candidates. The lung CAS thresholds vary depending on whether the donor is blood type O, as many more candidates appear on the match for blood type O donors than for donors of other blood types. The following thresholds were selected to capture a similar proportion of PTRs on the match regardless of donor blood type:

- Blood type O donors
    - Very high CAS threshold: 41
    - High CAS threshold: 35
    - Lower CAS threshold: 34

- Blood type A, B, and AB donors
    - Very high CAS threshold: 37
    - High CAS threshold: 31
    - Lower CAS threshold: 30

These lung CAS thresholds are incorporated into the multi-organ allocation tables. A PTR is above the threshold if their score on the match, inclusive of placement efficiency points and any approved exception points, is greater than the threshold. Lung-alone PTRs with a CAS above the thresholds would also receive lung offers in the order they appear on the match. The proposed lung CAS thresholds are higher for blood type O donors because blood type O candidates receive additional points for blood type

to be prioritized for these donors, thereby raising the overall distribution of scores for PTRs appearing on those matches.

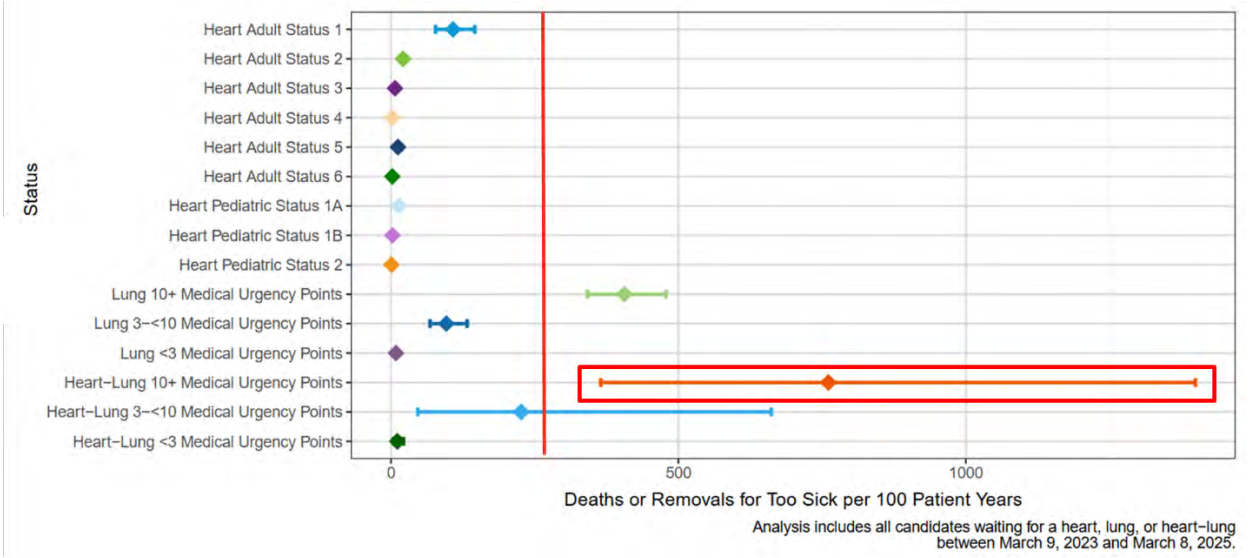
All of these thresholds are higher than the lung CAS threshold of 25 in the current heart-lung, lung-kidney, and lung-liver policies. To ensure these thresholds appropriately balance access to transplant for lung multi-organ candidates with organ placement efficiency, the Workgroup reviewed the number and proportion of PTRs on the match who would fall above these thresholds, including whether they were a multi-organ or lung-alone candidate, and the distribution of medical urgency scores for these candidates. These thresholds would capture:

- An average of one-quarter to one-third of lung multi-organ candidates on each match run for the donors identified by the Committee
- Medically urgent and pediatric lung-alone candidates

For donors with a final acceptor on the lung match between September 28, 2023 - August 31, 2024, the lungs from blood type O donors were placed above these thresholds more than 75% of the time for DBD donors and 50% of the time for DCD donors. The lungs from non-O blood type donors were placed above these thresholds more than 50% of the time for DBD donors and more than 25% of the time for DCD donors. Since lungs are often placed within these thresholds in current allocation, it does not appear that raising the lung CAS thresholds for multi-organ allocation will negatively impact access to transplant for lung multi-organ candidates. The placement percentages are lower for the non-O donors because a much smaller number of PTRs appear on those matches, so OPOs will be sending fewer offers on those matches before completing the multi-organ allocation tables.

Following the *Request for Feedback*, the Committee opted to add the "very high" lung CAS threshold in addition to the lower two thresholds to address concerns about access to transplant for very medically urgent heart-lung candidates. Under current policy, heart allocation primarily drives placement of heart-lungs, such that candidates typically need to have a high adult heart status to receive a heart-lung transplant. The Workgroup expressed concerns about access to transplant for heart-lung candidates with very high lung medical urgency scores who may not receive sufficient organ offers under the current policy. As shown in *Figure 7*, heart-lung candidates with high lung medical urgency scores have higher waitlist mortality than adult heart Status 2 candidates. Accordingly, the Committee proposes adding this very high lung CAS threshold for the most medically urgent candidates on the lung match, including heart-lung candidates, to receive offers ahead of candidates in the classifications for heart Status 2. This threshold was selected because the historic cohort of heart-lung candidates who would have met this threshold almost always had 10 or more medical urgency points, placing these candidates in the top 5% of medical urgency scores relative to all candidates on the lung waiting list.[20]

Figure 7: Deaths or Removals for Too Sick per 100 Patient Years on the Waiting List by Organ Type and Candidate Status



More information on the data reviewed by the Workgroup can be found in the workgroup meeting summaries on the OPTN website.[21]

System solution

The MOT Committee has requested development of a system solution that would guide the user through the proposed multi-organ allocation tables. The system solution would be known as the "Multi-organ allocation plan," a system-generated, donor-specific plan that displays the order in which the user should make organ offers across the different match runs, in accordance with the multi-organ allocation policy tables in *Policy 5.10.* As discussed in *Allocation process*, above, OPOs would be required to run match runs and generate an allocation plan.

[20] *OPTN summary of CAS subscores used for allocation in active lung registrations as of May 27, 2025*, https://optn.transplant.hrsa.gov/media/m4magzot/lung_cas_scores.pdf (accessed June 5, 2025).
[21] OPTN Ad Hoc Multi-Organ Transplantation Committee, https://optn.transplant.hrsa.gov/about/committees/ad-hoc-multi-organ-transplantation-committee/ (accessed June 3, 2025).

The Committee has received community feedback on the system solution through user research with OPOs, consultation with the OPO Committee, and during the Winter 2025 public comment cycle. Noting the complexity of multi-organ allocation policy, stakeholders have called for a system solution that effectively and efficiently guides users through allocation and helps promote compliance. Specifically, participants called for:

- Clear and easy-to-follow allocation plans
- Color coding
- Navigational aids
- Notifications when an OPO user needs to switch between match runs
- Warnings when OPO users attempt to make an offer from an incorrect match run

For example, during the Winter 2025 public comment cycle the OPO Committee commented "[t]he Committee understands that a single-match run is not feasible at this stage. To facilitate the navigation of multiple match runs, the Committee suggests that the IT system provides notifications of when an OPO operator needs to switch between match runs to reduce potential errors and a warning for if an OPO operator attempts to make an offer on an incorrect match run."

Proposed revisions to other policies

Consolidating multi-organ allocation policy

Currently, multi-organ allocation policy is addressed in several different sections of OPTN policy. This proposal would consolidate multi-organ allocation policy within *Policy 5.10: Allocation of Organs from Deceased Multi-Organ Donors.* Consolidating multi-organ allocation policy may help increase understanding of the policy among patients, donor families, and transplant professionals, and promote compliance. Consequently, the policy proposal would delete the following policies addressing specific multi-organ combinations:

- 5.10.E: Allocation of Heart-Kidneys
- 5.10.F: Allocation of Lung-Kidneys
- 5.10.G: Allocation of Heart-Liver and Lung-Liver
- 6.6.F: Allocation of Heart-Lungs
- 8.6.C: Kidney Allocation in Multi-Organ Combinations
- 9.9: Liver-Kidney Allocation

Policy 1.2: Definitions

The policy proposal would add two definitions and revise one definition in *Policy 1.2: Definitions.* The proposal defines "Deceased multi-organ donor," the group of donors to whom *Policy 5.10* potentially applies. It also defines "Multi-organ allocation plan," the system-generated donor-specific plan to guide users through *Policy 5.10.*

The proposal would also revise the definition of "Primary potential transplant recipient" as "the highest priority potential transplant recipient on a match run." As discussed in *Allocation Process,* above, OPOs are required to generate a multi-organ allocation plan prior to making organ offers to primary PTRs.

Policy 5.4.B: Order of Allocation

The proposal would revise *Policy 5.4.B: Order of Allocation* to make it clear that OPOs must allocate organs from deceased multi-organ donors according to *Policy 5.10.*

Policy 5.6.D: Effect of Acceptance

The proposal would revise *Policy 5.6.D: Effect of Acceptance* to make it clear that once an organ has been accepted by a transplant program for a primary PTR, it is no longer available to be offered to other candidates, including multi-organ candidates, unless the transplant hospital and OPO mutually agree on alternative allocation of the organ.

Policy 8.6.A: Choice of Right versus Left Donor Kidney

The proposal would simplify *Policy 8.6.A: Choice of Right versus Left Donor Kidney* so that the transplant hospital that received the offer for the potential transplant recipient with higher priority would select whether to receive the right or left kidney. To promote consistent allocation practices, the proposal would remove OPO discretion on which kidney to offer in certain circumstances.

Policy 9.8.F: Allocation of Livers from Non-DCD Deceased Donors 11-17 Years Old and 9.8.J: Allocation of Liver-Intestines from Non-DCD Donors 11 to 17 Years Old

The proposal would merge *Policy 9.8.F: Allocation of Livers from Non-DCD Deceased Donors 11-17 Years Old* and *Policy 9.8.J: Allocation of Liver-Intestines from Non-DCD Donors 11 to 17 Years Old.* Currently, *Policy 9.8.J* requires that liver-intestines are offered sequentially to potential transplant recipients in Liver Classifications 1-23 in *Table 9-12: Allocation of Livers from Non-DCD Deceased Donors 11 to 17 Years Old* and OPOs may then offer liver-intestines from the intestine match run. The MOT Committee adjusted the order of priority in *Table 5-11: Allocation table for non-DCD multi-organ donors 11 to 17 years old with KDPI less than or equal to 34%* so that Liver Classifications 1-23 are above the intestine classifications, so that it is consistent with *Policy 9.8.J.*

The proposal would remove the provision for liver-intestine offers from the intestine match run, as this is not consistent with other donor groups, and to maintain access to transplant for medically urgent liver candidates.

Policy 9.12.B: Closed Variance for Allocation of Blood Type O Deceased Donor Livers

The proposal would revise *Policy 9.12.B: Closed Variance for Allocation of Blood Type O Deceased Donor Livers* to ensure that the closed variance, which applies to liver and liver-intestine allocation by OPOs in Hawaii and Puerto Rico, would take precedence over *Policy 5.10.*

Policy 11.4.A: Kidney-Pancreas Allocation Order

The proposal would revise *Policy 11.4.A: Kidney-Pancreas Allocation Order* to ensure that *Policy 5.10* applies to donors covered by a multi-organ allocation table with kidney(s) and pancreas available. For donors not covered and for donors that have kidney(s) and pancreas available after all offers have been made according to the multi-organ allocation plan, OPOs may:

- Offer the kidney and pancreas according to *Policy 11: Allocation of Pancreas, Kidney-Pancreas, and Islets*; or
- Offer the pancreas according to *Policy 11: Allocation of Pancreas, Kidney-Pancreas, and Islets* and the kidney(s) according to *Policy 8: Allocation of Kidneys*

Other considerations

Considerations for patients and donor families

The proposal aims to promote equitable access to transplant among multi- and single-organ candidates. Specifically, it aims to increase access to transplant for high priority single-organ candidates, such as medically urgent, highly sensitized, and pediatric candidates by removing priority for some multi-organ candidates above all single organ candidates.

It aims to ensure consistent allocation practices across the country by standardizing allocation processes and order of priority across match runs for high priority candidate groups. Standardization would help increase transparency and allow transplant programs and candidates to better understand candidates' priority and potential waiting times. It also helps to honor the gift of life by ensuring that organs are offered to the highest priority candidates.

Additionally, the proposal aims to strengthen the allocation system by facilitating stronger monitoring of outcomes, compliance, and allocation out of sequence. It seeks to promote system efficiencies through consolidation of multi-organ policy and development of a comprehensive system solution to guide users and promote compliance with complex policy.

Allocation out of sequence

During the Winter 2025 public comment cycle, some participants asked how this policy proposal would impact allocation out of sequence allocation and how it intersects with other OPTN work on allocation out of sequence. Noting the limitations discussed in *Limitations on predicting impacts,* above, the MOT Committee considers that this project complements other OPTN work on allocation out of sequence as the policy changes and system solution would facilitate stronger monitoring of outcomes and compliance, including allocation out of sequence in the context of multi-organ allocation.

Limitations on predicting impacts

As described in this proposal and the Winter 2025 request for feedback, the MOT Committee has reviewed extensive historic data. During the Winter 2025 public comment cycle, some participants requested modelling or additional data analysis to better understand the potential impacts of the proposed changes generally, and on specific patient groups including pediatric liver-kidney candidates. Currently, modelling is not available in the context of multi-organ allocation. Additionally, as policy does not currently direct the order in which OPOs make offers across match runs, analysis of historic data cannot predict how the proposed policy changes will impact access to transplant, organ non-use, and other areas of concern.

The inability to fully predict the potential impacts is partly due to the limited nature of current multi-organ allocation policy, including that policy does not direct the order in which OPOs make offers across match runs and that policy does not comprehensively address which organs can follow other organs on the primary match run. Although there are risks of unintended consequences, adoption of this policy proposal and implementation of the system solution would allow for stronger monitoring of outcomes and compliance moving forward.

NOTA and Final Rule Analysis

The Committee submits this policy proposal under the authority of the National Organ Transplant Act of 1984 (NOTA), which states that the OPTN shall "establish... medical criteria for allocating organs…,"[22] as well as the OPTN Final Rule, which states that, "[t]he OPTN Board of Directors shall be responsible for developing... [p]olicies for the equitable allocation of cadaveric organs..."[23] The proposal would make significant changes to allocation policy for most donors with at least two different organs available for donation, by standardizing allocation process and order of priority for highly prioritized candidate groups. It aims to promote equitable access to transplant among multi- and single-organ candidates and to facilitate consistent and efficient allocation practices.

The Final Rule requires that when developing policies for the equitable allocation of cadaveric organs, such policies must be developed "in accordance with §121.8", which requires that allocation policies "(1) Shall be based on sound medical judgment; (2) Shall seek to achieve the best use of donated organs; (3) Shall preserve the ability of a transplant program to decline an offer of an organ or not to use the organ for the potential recipient in accordance with §121.7(b)(4)(d) and (e); (4) Shall be specific for each organ type or combination of organ types to be transplanted into a transplant candidate; (5) Shall be designed to avoid wasting organs, to avoid futile transplants, to promote patient access to transplantation, and to promote the efficient management of organ placement;…and (8) Shall not be based on the candidate's place of residence or place of listing, except to the extent required by paragraphs (a)(1)-(5) of this section."[24] This proposal:

- **Is based on sound medical judgment**[25] in that the Committee analyzed descriptive and inferential data including data on waitlist survival and post-transplant survival to inform allocation priority. The Committee also completed a VPE to help identify/build clinical consensus on organ allocation priorities across match runs, especially where clinical data is limited.
- **Seeks to achieve the best use of donated organs**[26] by requiring offers to both single- and multi-organ candidates in the order they appear on the match runs, which preserves the considerations for medical urgency that are incorporated into the organ-specific allocation policies. To inform prioritization across match runs, the Committee analyzed data and completed a VPE, as described above.
- **Is designed to…promote patient access to transplantation**[27] by promoting equity in access to transplant among multi- and single- organ candidates, including highly-sensitized and medically urgent single-organ candidates who may currently experience limited access to transplant as compared to multi-organ candidates.
- **Would promote the efficient management of organ placement**[28] by directing allocation order for donors with at least two different organs available for transplantation. Under current OPTN policy, organ procurement organizations (OPOs) must follow match runs, but have discretion to decide the order in which they will make offers across different organ match runs. OPOs report that multi-organ allocation tends to be resource-intensive and that there are inconsistent practices under current policy.

[22] 42 USC §274(b)(2)(B).
[23] 42 CFR 121.4(a)(1).
[24] 42 CFR §121.8(a).
[25] 42 CFR §121.8(a)(1).
[26] 42 CFR §121.8(a)(2).
[27] 42 CFR §121.8(a)(5).
[28] 42 CFR §121.8(a)(5).

- **Is not based on the candidate's place of residence or place of listing**.[29]

This framework would also preserve the ability of a transplant program to decline an offer or not use the organ for a potential recipient,[30] and it is specific for each organ type or combination of organ types to be transplanted,[31] as the proposed allocation order would maintain the organ-specific criteria used to prioritize candidates waiting for transplantation.

The framework is not expected to have a significant impact on the Final Rule requirement that allocation policies shall be designed to avoid futile transplants,[32] though the Committee considered post-transplant survival data when determining the order of priority across organ-specific match runs. It is not expected to have a significant impact on the Final Rule requirement to avoid wasting organs,[33] though the project does aim to promote efficiency in allocation for OPOs and may reduce delays in allocation that can contribute to organ non-use. Additionally, the approach is tailored towards donors whose organs that are likely to be used for multi-organ transplants and excludes more medically complex donors so that their organs can be allocated through the appropriate pathways.

Transition procedures

The Final Rule also requires the OPTN to "consider whether to adopt transition procedures that would treat people on the waiting list and awaiting transplantation prior to the adoption or effective date of the revised policies no less favorably than they would have been treated under the previous policies" whenever organ allocation policies are revised.[34] Noting the removal of priority for some kidney multi-organ candidates above all single organ candidates, the Committee considered whether transition procedures would be needed to support implementation. The Committee determined that transition procedures would not be needed because the proposed policy aims to promote equitable access to transplant among multi- and single-organ candidates, including strengthening access for medically urgent, highly-sensitized, and pediatric single organ candidates. Additionally, the Committee noted that transition procedures may add additional complexity to the implementation process. The Committee emphasized the importance of community outreach and pre-implementation training to help users transition and promote compliance.

Implementation Considerations

Member and OPTN Operations

The proposal is expected to impact member and OPTN operations, as described below.

Operations affecting the OPTN

To support effective implementation of this complex policy proposal, the OPTN would need to provide significant support to facilitate compliance, including development of a system-generated, donor specific allocation plan and pre-implementation training.

[29] 42 CFR §121.8(a)(8).
[30] 42 CFR §121.8(a)(3).
[31] 42 CFR §121.8(a)(4).
[32] 42 CFR §121.8(a)(5).
[33] 42 CFR §121.8(a)(5).
[34] 42 CFR §121.8(d)(1).

Additionally, the proposed policy changes and system solution would facilitate stronger monitoring of outcomes and compliance, which would complement other OPTN efforts to address allocation out of sequence.

As other organs transition to continuous distribution, multi-organ allocation policy would need to be revised to insert CAS thresholds into the multi-organ policy tables. The process that the MOT Committee and Lung-MOT Workgroup developed to determine appropriate lung CAS thresholds could be used to identify appropriate CAS thresholds for other organs. The MOT Committee plans to partner with other OPTN Committees to facilitate integration of continuous distribution and multi-organ policies moving forward.

Operations affecting Organ Procurement Organizations

The proposal would make significant changes to allocation of organs from donors with at least two organs available. The proposed changes are expected to have a significant impact on OPO operations, in particular, the requirements to generate an allocation plan and to make organ offers according to the plan. Although the proposed changes intend to reduce the burden on OPOs by providing system-generated, donor-specific guidance, OPOs may need to review and update internal policies and, with the support of the OPTN, ensure staff receive appropriate information and training to ensure successful implementation and realize potential efficiencies.

Operations affecting Transplant Hospitals

The proposal is expected to have low impacts on transplant hospital operations. Transplant hospitals would need to ensure that staff are familiar with the policy changes and understand the impacts on candidates, especially the removal of “permissible” multi-organ offers and the shift to a “must” or “must not” offer framework for candidates registered for more than one organ.

Operations affecting Histocompatibility Laboratories

The proposal is expected to have minimal impacts on histocompatibility laboratory operations. The proposed changes may increase requests for virtual cross-matching.

Potential Impact on Select Patient Populations

The proposal aims to promote equitable access to transplant among multi- and single-organ candidates. In particular, it standardizes order of priority across match runs and removes priority for some multi-organ candidates above high priority single candidates, which is expected to improve access to transplant for very medically urgent, highly-sensitized, and pediatric single organ candidates.

As discussed in *Limitations on predicting impacts,* above, modeling is not available for multi-organ allocation and analysis of historic data cannot predict how the proposed policy changes will impact access to transplant, organ non-use, and other areas of concern. Adoption of this policy proposal and implementation of the system solution would allow for stronger monitoring of outcomes and compliance moving forward.

The section *Post Implementation Monitoring* describes the ways in which the OPTN will monitor member compliance and evaluate the outcomes. This will include evaluating impacts of select

populations and other potential areas of concern identified by the Committee and participants in the Winter 2025 public comment cycle, including impacts on:

- Out of sequence allocation in the context of multi-organ allocation
- Pediatric candidates, including liver-kidney candidates
- Organ non-use and utilization, including of pancreata
- Candidates in relatively highly prioritized candidate groups outside of the multi-organ allocation tables
- Allocation efficiency

Projected Fiscal Impact

The Fiscal Impact Advisory Group, comprised of representatives from histocompatibility laboratories, organ procurement organizations, and transplant hospitals, reviewed this proposal and completed a survey to estimate anticipated costs. They rated this project as low, medium, or high based on the estimated staffing and/or training, overtime, equipment, or IT support needed in the implementation of this proposal.

Overall Projected Fiscal Impact

This proposal is expected to have a medium impact on organ procurement organizations and a low impact on transplant programs. There are no significant expected fiscal impacts for histocompatibility labs.

Projected Impact on Organ Procurement Organizations

There is a medium expected fiscal impact on organ procurement organizations as they adjust to updated policy and procedure. OPOs may have increased costs associated with education and training, as well as increased time spent on organ allocation as staff acclimates to the updated procedures.

Projected Impact on Transplant Hospitals

There is a low expected fiscal impact on transplant hospitals.

Projected Impact on Histocompatibility Laboratories

There were no significant fiscal impacts indicated with this proposal.

Projected Impact on the OPTN

It is estimated that $(redacted) would be needed to implement this proposal. Implementation would involve updates to the OPTN Computer System that include developing the solution, coding, and testing to support the updated policy requirements and associated system tools. In addition, implementation would include building communications and education materials, updating process documents, and community outreach. It is estimated that $(redacted) would be needed for ongoing support. Ongoing support includes member support and education, compliance monitoring, system maintenance, and answering member questions as necessary. In addition, ongoing support will include a monitoring

report at the 6-month, 1-year, and 2-year timeframes. The total for implementation and ongoing support is estimated to be $(redacted).[35]

The timeline for implementation of the system solution will be finalized after the OPTN Board of Directors considers and approves this proposal. The implementation and ongoing costs described above are likely to be incurred over a multi-year period.

Post-implementation Monitoring

Member Compliance

The Final Rule requires that policies "include appropriate procedures to promote and review compliance."[36] An OPTN contractor, on behalf of the OPTN, will continue to review deceased donor match runs that result in a transplanted organ to ensure that organs have been allocated according to OPTN Policy and will continue to investigate potential policy violations that are identified. For deceased multi-organ donors, the allocation review will include verification that:

- Organs were allocated according to the multi-organ allocation tables in *Policy 5.10: Allocation of Organs from Deceased Multi-Organ Donors*
- Multi-organ allocation plans were generated utilizing the appropriate organ match runs according to *Policy 5.10.B: Allocation Process* and *Policy 5.10.C: Re-executing Multi-Organ Allocation Plans*
- Organs were offered to the appropriate PTRs according to the medical eligibility criteria in *Policy: 5.10.E* and in accordance with requirements in *Table 5-4 Multi-Organ Offers*

During transplant hospital site surveys, an OPTN contractor, on behalf of the OPTN, will continue to review a sample of medical records and any material incorporated into the medical record by reference, to verify that data reported in the OPTN Computer System are consistent with source documentation, including eligibility criteria for adult heart-kidney, lung-kidney, and liver-kidney candidates. Any data entered into OPTN computer systems may be reviewed by the OPTN, and members are required to provide documentation as requested.

Policy Evaluation

The Final Rule requires that allocation policies "be reviewed periodically and revised as appropriate."[37] This policy will be considered successful if appropriate access to transplant is provided for multi-organ candidates without disproportionate impact on single-organ candidates. To evaluate whether this policy is successful, monitoring reports using pre- vs. post-policy comparisons will be presented to the Committee approximately 6 months, 1 year, and 2 years post-implementation. These monitoring reports will include the following single- and multi-organ combinations as data and sample size permit:

- Heart
- Heart-Lung
- Lung

[35] Resource estimates are calculated by the current contractor for that contractor to perform the work. Estimates are subject to change depending on a number of factors, including which OPTN contractor(s) will be performing the work, if the project is ultimately approved. Resources estimates are exempted from public disclosure under the Freedom of Information Act exemption 4.
[36] 42 CFR §121.8(a)(7).
[37] 42 CFR §121.8(a)(6).

- Liver
- Multivisceral (MVT; includes liver-intestine, liver-intestine-pancreas, liver-intestine-pancreas-kidney, liver-intestine-kidney)
- Kidney
- Kidney-Pancreas/Pancreas

Key metrics that will be evaluated pre- vs. post-policy include:

1. Number and proportion of multi-organ and single-organ candidates transplanted pre- vs. post-policy
2. Median waiting time to transplant for multi- and single-organ candidates pre- vs. post-policy
3. Median time from start of first match run (e.g., electronic notification time) to recovery of donor organs (e.g., cross-clamp time) pre- vs. post-policy. Alternative timestamps may be explored as data become available.

Key metrics will be stratified by organ combination, medical urgency, recipient classification, and age (pediatric: <18 years vs. Adult: 18+ years) when appropriate. Special attention will be paid to heart-kidney, MVT (especially those who also require pancreata), heart-lung, pancreas, and pediatric populations to ensure that these candidates/recipients are adequately prioritized by the proposed MOT allocation tables, as highlighted below. Additional supporting metrics that will be evaluated pre- vs. post-policy include:

Waiting List

- Number and proportion of waiting list additions by single- or multi-organ combination, overall and stratified by:
    - medical urgency at listing
    - age at listing: pediatric (<18 years) vs. adult (18+ years)
- Number and proportion of waiting list removals by single- or multi-organ combination, overall and stratified by:
    - medical urgency at removal
    - age at removal: pediatric (<18 years) vs. adult (18+ years)
    - removal reason
- Due to Committee interest, the number of MVT waiting list additions and removals will also be shown by MVT type (i.e., liver-intestine, liver-intestine-pancreas, liver-intestine-kidney-pancreas, liver-intestine-kidney) in the report
- Waiting list mortality rates (or counts, if sample size is insufficient) by single- or multi-organ combination, overall and stratified by:
    - medical urgency
    - age: pediatric (<18 years) vs. adult (18+ years)

Donors

- Number and proportion of donors overall and stratified by:
    - Organ (heart, intestine, kidney, liver, lung, pancreas)
    - MOT donor type:
        - DBD age 18-69, KDPI 0-34%
        - DBD age 18-69, KDPI 35-85%
        - DCD age 18+, KDPI 0-34%
        - DCD age 18+, KDPI 35-85%

        - DBD age 11-17, KDPI 0-34%
        - DBD age <11, KDPI 0-34%
        - DBD age <11, KDPI 35-85%
        - Donor outside of proposed MOT allocation
- Utilization rates by organ (heart, intestine, kidney, liver, lung, pancreas)
- Non-use rates by organ (heart, intestine, kidney, liver, lung, pancreas)
- Due to Committee interest, pancreas utilization and non-use will be highlighted separately in the report

Transplants

- Number and proportion of transplants by single- or multi-organ combination, overall and stratified by:
    - recipients' medical urgency at transplant
    - age at transplant: pediatric (<18 years) vs. adult (18+ years)
    - MOT donor type
    - whether or not the recipients' classification at transplant would have been covered by the proposed allocation tables
- Due to Committee interest, MVT transplants will also be shown by MVT type (i.e., liver-intestine, liver-intestine-pancreas, liver-intestine-kidney-pancreas, liver-intestine-kidney) in the report
- For multi-organ transplant recipients not covered by the proposed multi-organ allocation tables:
    - The classification under which the primary organ was transplanted
    - Stratifications by organ combination and:
        - recipient age: pediatric (<18 years) vs. adult (18+ years)
        - medical urgency status
    - Due to Committee interest, heart-kidney, heart-lung, and MVT recipients not covered by the proposed multi-organ allocation tables will be highlighted separately in the report. For these recipients, both the primary organ classification and the secondary organ medical urgency will be shown
- Transplant rates (or counts, if sample size is insufficient) for single- and multi-organ candidates, overall and stratified by:
    - medical urgency
    - age: pediatric (<18 years) vs. adult (18+ years)
- Median waiting time to transplant for multi- and single-organ candidates, overall and stratified by:
    - medical urgency
    - age: pediatric (<18 years) vs. adult (18+ years)

Match Run

- Median time from start of first match run (e.g., electronic notification time) to recovery of donor organs (e.g., cross-clamp time), overall and stratified by OPTN region
- For each organ with a match run with a final acceptance, the number of offers sent and the distribution of the sequence number/appearances for each classification within the required allocation algorithm

Pediatrics

- Waiting list additions by organ combination, age group, and medical urgency status
- Waiting list mortality by organ combination, age group, and medical urgency status

- Transplants by organ combination, age group, and medical urgency status
- Number of pediatric multi-organ recipients whose classifications were covered vs. not covered by the proposed MOT allocation tables, overall and stratified by age group
- Distribution of primary organ classification and secondary organ medical urgency for pediatric recipients not covered by the proposed allocation tables, overall and stratified by age group

Conclusion

Currently, multi-organ allocation can be resource intensive, contribute to inefficiencies in allocation, and may impact access to transplant for highly-sensitized, medically urgent, and pediatric single-organ candidates. This proposal aims to promote equitable access to transplant among multi- and single-organ candidates and to facilitate consistent and efficient allocation.

The proposal would standardize the order of priority across different organ match runs by inserting multi-organ allocation tables into policy. The tables cover 98% of donors to multi-organ recipients and 77.8% of multi-organ recipients who received a transplant from covered donors.[38] For donors not covered by an allocation table, or if two or more organs remain unplaced after completion of the table, OPOs would decide the order in which they make offers across match runs. This approach standardizes allocation for most donors and high priority candidate groups and allows flexibility to place organs that are not usually donated to multi-organ recipients.

To promote equitable access to transplant among multi- and single- organ candidates, the Committee recommends removing priority for some kidney-multi-organ candidates and requiring that offers be made to both single- and multi-organ candidates as directed by the multi-organ allocation tables, which would include some offers to kidney-alone candidates ahead of some multi-organ candidates. To promote consistent allocation, the proposal would establish a binary “must”/”must not” offer framework for candidates registered for more than one organ and establish which organs follow the primary organ on each match run. OPOs would be required to run relevant match runs and generate a system-generated, donor specific multi-organ allocation plan prior to making offers to primary potential transplant recipients.

To support implementation, the Committee requested development of a system-generated, donor specific multi-organ allocation plan to guide users through the multi-organ allocation tables. Additionally, the Committee supports pre-implementation training to help users transition and promote compliance.

Currently, modelling is not available in the context of multi-organ allocation. Additionally, as policy does not currently direct the order in which OPOs make offers across match runs, analysis of historic data cannot predict how the proposed policy changes will impact access to transplant, organ non-use, and other areas of concern.

The Committee believes that the proposed changes would significantly improve the allocation system by promoting equitable access to transplant among multi- and single-organ candidates and facilitating consistent, transparent, and efficient allocation. The Committee looks forward to the community’s feedback.

[38] OPTN Descriptive Data request, “Multi-Organ Transplant Recipients Not Covered by Proposed Allocation Tables Data Request.” Prepared for MOT Committee Conference Call, March 26, 2025.

Considerations for the Community

The Committee requests the community's input on the proposed policy changes, including the following questions:

1. **Does the community support the donors covered by multi-organ allocation tables?**
2. **Does the community support the candidate groups covered by the multi-organ allocation tables?**
3. **Does the community support the order of priority of candidate groups in the multi-organ allocation tables?**
4. **Does the community support moving to a "must"/"must not" offer framework for candidates registered for more than one organ and removing "permissible" multi-organ offers?**
5. **Does the community support removing priority for some heart-kidney, liver-kidney, lung-kidney, and kidney-pancreas candidates above kidney-alone candidates?**
6. **Does the community support the proposed policy on which organs would follow the primary organ on each match run?**
    a. All organs would follow the primary organ on the heart, lung, and liver match runs
    b. Only intestine, kidney, pancreas, and covered VCA would follow on the intestine, kidney, and kidney-pancreas match runs
    c. On VCA match runs, only covered VCA would follow
    d. Islets would not follow organs and organs would not follow islets
7. **Does the community support the proposed revisions to *Policy 5.6.D: Effect of Acceptance*?**
8. Under the proposed policy, OPOs would be required to execute match runs for organs to be recovered for transplantation and generate the allocation plan before making an organ offer to a primary potential transplant recipient. **Does the community support the timing for running the allocation plan relative to executing match runs and making offers to primary PTRs?**
9. **Would it be feasible to report HLA Typing prior to generating a multi-organ allocation plan?**
10. What **challenges** do members anticipate if the policy proposal is implemented and **how should the OPTN support members to ensure successful implementation and promote compliance**?
11. The Committee has previously identified the following groups for additional post-implementation outcome monitoring to ensure that these candidates/recipients are adequately prioritized in the proposed MOT allocation tables. **Are there other groups or topics that should have additional post-implementation monitoring to help identify and remediate any unintended impacts**?
    a. Heart-Kidney candidates and recipients
    b. Heart-Lung candidates and recipients
    c. Multivisceral candidates and recipients, especially those who also require pancreata
    d. Pancreata use rate and utilization rate
    e. Pediatric candidates and recipients

Appendices

Appendix 1: Allocation table for non-DCD multi-organ donors 18 to 69 years old with KDPI less than or equal to 34% showing key data points and rationale for placement

Table 1-1 shows the order of priority for non-DCD multi-organ donors 18 to 69 with KDPI of 0-34% and:

- **Median appearances:**[39] The median number of registrations that appeared in each classification on all match runs with a final acceptance (February 1, 2023-December 31, 2023). The data indicate how frequently registrations appear, on average, on a match run for a donor covered by this table, whether or not the registration was extended an offer. This provides a sense of the volume of candidates that have historically been captured in the classifications in the allocation tables.
- **Median waitlist survival**:[40] Median estimated risk for 1-year survival pretransplant for candidates within the class (July 1, 2021-June 30, 2023).
- **Median post-transplant survival:** Median predicted 1-year graft survival for candidates within the class (July 1, 2021-June 30, 2023).
- **Median time without an offer:** Mean time in days candidates within the class went without an organ offer (July 1, 2021-June 30, 2023).
- **Percent without offer:** The proportion of candidates in the class that did not receive an organ offer during the cohort time frame (July 1, 2021-June 30, 2023).
- **Rationale for placement:** Brief description of the Committee's rationale for prioritization of classification.

[39] Median appearance data are from: OPTN Descriptive Data Request, "Efficiency/Small Populations Data Request." Prepared for the MOT Committee Conference Call on May 14, 2025. The data request analyzed heart, heart-lung appearing on heart match, liver, liver-intestine, kidney and kidney-pancreas/pancreas match runs executed for deceased donors between 02/01/2023 and 12/31/2023; and OPTN Descriptive Data Request, "Lung Multi-Organ CAS Thresholds and Heart-Lung Waiting List Mortality Data Request." Prepared for the Lung-MOT Workgroup Conference Call on May 13, 2025. The data request analyzed lung and heart-lung appearing on lung match runs executed for deceased donors between 09/28/2023 and 08/31/2024.

[40] Waitlist survival, post-transplant survival, time without offer, and percent without offer data are from: Scientific Registry of Transplant Recipients, "Considerations for the Order of Multiorgan Allocation", July 26, 2024, and Addendum 1, September 13, 2024.

Table 1-1: Allocation table for non-DCD multi-organ donors aged 18 to 69 years old with KDPI less than or equal to 34% showing key data points and rationale for placement

Organ classification and description[41]	Median appearances	Median waitlist survival	Median post-tx survival	Median time without offer	Percent without offer	Rationale for placement
Liver Class 1: Status 1A (adult and pediatric); 500NM	0	94.3	86.8	2	14	Medical urgency. No life-sustaining technology.
Heart Class 1: Adult Status 1 or Pediatric Status 1A; 500NM	1	85.1	90.3	12	26	Medical urgency.
Heart Class 2: Adult Status 1 or Ped Status 1A; 500NM	0	85.1	91.3	34	80	
Liver Class 2: Status 1B; 500NM	0	94.8	88.1	3	8	Medical urgency. Pediatric access to transplant.
Liver Class 3: Status 1A; HI or PR	0	94.3	81.1	2	10	
Liver Class 4: Status 1B; HI or PR	0	94.8	93.7	--	--	
Lung CAS: 41 for O donors; 37 for non-O donors	O donor: 7 Non-O donor: 2					Medical urgency. Access to transplant.
Heart Class 3: Adult Status 2; 500NM	10	82.1	91.7	4	14	Medical urgency. Access to transplant.
Heart Class 4: Adult Status 2; 500NM	0	82.1	92.2	16	76	
Lung CAS: 35 for O donors; 31 for non-O donors	O donor: 16 Non-O donor: 4					Medical urgency.
Kidney Class 1: 0-ABDR mismatch; CPRA =equal to 100%; 250NM	0	95.9	95.5	449	98	Access to transplant. Small population.
Kidney Class 2: CPRA equal to 100%; 250NM	0	95.9	94.3	178	72	
Kidney Class 3: 0-ABDR mismatch; CPRA equal to 100%; nation	0	95.9	95.5	407	92	
Kidney Class 4: CPRA equal to 100%; nation	0	95.9	94	84	45	
Kidney Class 5: Prior living donor; 250NM	0	96.2	93.8	37	25	Honor gift of life.
Liver Class 5: MELD/PELD of at least 37; 150NM	0	72.6	88.4	4	40	Medical urgency.
Liver Class 6: MELD/PELD of at least 37; 150 NM	0	72	88.3	5	46	
Liver Class 7: MELD/PELD of at least 37; 250NM	0	72.6	88.9	3	25	
Liver Class 8: MELD/PELD of at least 37; 250NM	0	72	88.7	3	31	
Liver Class 9: MELD/PELD of at least 37; 500NM	2	72.6	89.3	2	11	
Liver Class 10: MELD/PELD of at least 37; 500NM	1	72	89	2	13	
Liver Class 11: MELD/PELD of at least 37; HI/PR	0	72.6	91.1	2	0	

[41] Most blood type information omitted from organ classification description for brevity.

Organ classification and description[41]	Median appearances	Median waitlist survival	Median post-tx survival	Median time without offer	Percent without offer	Rationale for placement
Liver Class 12: MELD/PELD of at least 37; HI/PR	0	72	89.2	4	33	
Intestine Class 1: Status 1; 500NM	4.5	92.7	80	76	44	Access to transplant; no life-sustaining technology.
Intestine Class 2: Status 1; 500NM	1	92.7	89.2	137	69	
Intestine Class 3: Status 1; nation	5.5	92.7	81	51	26	
Intestine Class 4: Status 1; nation	2	92.7	90	107	62	
Lung CAS: 34 for O donors; 30 for non-O donors	O donor: 25 Non-O donor: 4					Medical urgency.
Pancreas or K/P Class 1: 0-ABDR mismatch; CPRA ≥ 80%; 250NM	0	94.6	96.7	361	98.5	Access to transplant. Utilization of pancreata.
Pancreas or K/P Class 2: CPRA ≥ 80%; 250NM	0	94.6	98.6	203	66	
Heart Class 5: Adult Status 3 or Pediatric Status 1B; 250NM	3	91.3	90.4	25	44	Medical urgency; pediatric access to transplant.
Heart Class 6: Adult Status 3 or Pediatric Status 1B; 250NM	0	91.3	91.2	60	87	
Pancreas or K/P Class 3: 0-ABDR mismatch; CPRA ≥ 80%; nation	0	94.6	96.2	355	97	Access to transplant. Utilization of pancreata.
Pancreas or K/P Classification 4: 250NM	27	95.7	90.1	96	43	
Kidney Class 6: Registered prior to 18 years old; 250NM	3	99.1	97.2	44	52	Access to transplant for pediatric candidates.
Kidney Class 7: Medically Urgent; 250NM	0	95.2	91.9	21	28	Medical urgency.
Kidney Class 8: 0-ABDR mismatch; CPRA equal to 99%; 250NM	0	95.3	95.5	339	98.2	Access to transplant.
Kidney Class 9: CPRA equal to 99%; 250NM	0	95.3	94.9	89	50.2	
Kidney Class 10: 0-ABDR mismatch; CPRA equal to 98%; 250NM	0	95.4	96.1	297	98.1	
Kidney Class 11: CPRA equal to 98%; 250NM	0	95.4	95.8	69	42	
Liver Class 13: MELD/PELD of at least 33; 150NM	1	79.9	92.8	7	49.7	Medical urgency.
Liver Class 14: MELD/PELD of at least 33; 150NM	0	79.6	92.7	6	54.1	
Liver Class 15: MELD/PELD of at least 33; 250NM	0	79.9	92.3	5	35.9	
Liver Class 16: MELD/PELD of at least 33; 250NM	0	79.6	92.2	5	39.6	
Liver Class 17: MELD/PELD of at least 33; 500NM	3	79.9	92.6	3	23.1	
Liver Class 18: MELD/PELD of at least 33; 500NM	1	79.6	92.4	3	23.3	
Liver Class 19: MELD/PELD of at least 30; O donor; O or B candidate; 150NM	1	80.8	91.3	10	49.9	
Liver Class 20: MELD/PELD of at least 29; O donor; O candidate; 150NM	0	81.6	93.7	9	54.9	
Liver Class 21: MELD/PELD of at least 29; non-O donor; any cand.; 150NM	1	81.7	93.8	11	61.9	
Liver Class 22: MELD/PELD of at least 30; O donor; O or B candidate; 250NM	1	80.8	91.2	8	39.4	

Organ classification and description[41]	Median appearances	Median waitlist survival	Median post-tx survival	Median time without offer	Percent without offer	Rationale for placement
Liver Class 23: MELD/PELD of at least 29; O donor; O candidate; 250NM	0	81.6	94.1	8	43.8	
Liver Class 24: MELD/PELD of at least 29; non-O donor; any cand.; 250NM	1	81.71	94.1	9	48.5	
Liver Class 25: MELD/PELD of at least 30; O donor; O or B candidate; 500NM	5	80.8	91.8	5	27.2	
Liver Class 26: MELD/PELD of at least 29; O donor; O candidate; 500NM	2	81.6	93.7	5	32.3	
Liver Class 27: MELD/PELD of at least 29; O donor; O candidate; 500NM	4	81.7	93.7	6	33.2	

Appendix 2: Multi-organ allocation tables showing median appearances

Allocation table for non-DCD multi-organ donors 18 to 69 years old with KDPI less than or equal to 34% showing median appearances

Table 2-1 shows the order of priority for non-DCD multi-organ donors 18 to 69 with KDPI of 0-34% and **median appearances.** Median appearances is the median number of registrations that appeared in each classification on match runs with a final acceptance.[42] The data provide information on the volume of candidates that would have historically been captured in the allocation table.

Table 2-1: Allocation table for non-DCD multi-organ donors 18 to 69 years old with KDPI less than or equal to 34% showing median appearances

Organ classification and description	Median appearances	Organ classification and description	Median appearances
Liver 1: Status 1A (adult and pediatric); 500NM	0	Pancreas or K/P 1: 0-ABDR mismatch; CPRA ≥ 80%; 250NM	0
Heart 1: Adult Status 1 or Pediatric Status 1A; 500NM	1	Pancreas or K/P 2: CPRA ≥ 80%; 250NM	0
Heart 2: Adult Status 1 or Ped Status 1A; 500NM	0	Heart 5: Adult Status 3 or Pediatric Status 1B; 250NM	3
Liver 2: Status 1B; 500NM	0	Heart 6: Adult Status 3 or Pediatric Status 1B; 250NM	0
Liver 3: Status 1A; HI or PR	0	Pancreas or K/P 3: 0-ABDR mismatch; CPRA ≥ 80%; nation	0
Liver 4: Status 1B; HI or PR	0	Pancreas or K/P 4: 250NM	27
Lung CAS: 41 for O donors; 37 for non-O donors	O donor: 7 Non-O donor: 2	Kidney 6: Registered prior to 18 years old; 250NM	3
Heart 3: Adult Status 2; 500NM	10	Kidney 7: Medically Urgent; 250NM	0
Heart 4: Adult Status 2; 500NM	0	Kidney 8: 0-ABDR mismatch; CPRA equal to 99%; 250NM	0
Lung CAS: 35 for O donors; 31 for non-O donors	O donor: 16 Non-O donor: 4	Kidney 9: CPRA equal to 99%; 250NM	0
Kidney 1: 0-ABDR mismatch; CPRA = 100%; 250NM	0	Kidney 10: 0-ABDR mismatch; CPRA equal to 98%; 250NM	0
Kidney 2: CPRA equal to 100%; 250NM	0	Kidney 11: CPRA equal to 98%; 250NM	0
Kidney 3: 0-ABDR mismatch; CPRA = 100%; nation	0	Liver 13: MELD/PELD ≥ 33; 150NM	1
Kidney 4: CPRA equal to 100%; nation	0	Liver 14: MELD/PELD ≥ 33; 150NM	0
Kidney 5: Prior living donor; 250NM	0	Liver 15: MELD/PELD ≥ 33; 250NM	0
Liver 5: MELD/PELD of at least 37; 150NM	0	Liver 16: MELD/PELD ≥ 33; 250NM	0
Liver 6: MELD/PELD of at least 37; 150 NM	0	Liver 17: MELD/PELD ≥ 33; 500NM	3
Liver 7: MELD/PELD of at least 37; 250NM	0	Liver 18: MELD/PELD ≥ 33; 500NM	1
Liver 8: MELD/PELD of at least 37; 250NM	0	Liver 19: MELD/PELD ≥ 30; O donor; O or B cand; 150NM	1
Liver 9: MELD/PELD of at least 37; 500NM	2	Liver 20: MELD/PELD ≥ 29; O donor; O cand; 150NM	0
Liver 10: MELD/PELD of at least 37; 500NM	1	Liver 21: MELD/PELD ≥ 29; non-O donor; any cand; 150NM	1
Liver 11: MELD/PELD of at least 37; HI or PR	0	Liver 22: MELD/PELD ≥ 30; O donor; O or B cand; 250NM	1
Liver 12: MELD/PELD of at least 37; HI or PR	0	Liver 23: MELD/PELD ≥ 29; O donor; O cand; 250NM	0
Intestine 1: Status 1; 500NM	4.5	Liver 24: MELD/PELD ≥ 29; non-O donor; any cand; 250NM	1
Intestine 2: Status 1; 500NM	1	Liver 25: MELD/PELD ≥ 30; O donor; O or B cand; 500NM	5
Intestine 3: Status 1; nation	5.5	Liver 26: MELD/PELD ≥ 29; O donor; O cand; 500NM	2
Intestine 4: Status 1; nation	2	Liver 27: MELD/PELD ≥ 29; non-O donor; any cand; 500NM	4
Lung CAS: 34 for O donors; 30 for non-O donors	O donor: 25 Non-O donor: 4		

[42] Median appearances for lung CAS thresholds were derived from a cohort of match runs between September 28, 2023-August 31, 2024, to account for implementation of Lung Continuous Distribution and other lung policy changes. Median appearances for all other classifications were derived from a cohort of match runs between February 1, 2023-December 31, 2023.

Allocation table for non-DCD multi-organ donors 18 to 69 years old with KDPI of 35-85% showing median appearances

Table 2-2 shows the order of priority for non-DCD multi-organ donors 18 to 69 with KDPI of 35-85% and **median appearances**. Median appearances is the median number of registrations that appeared in each classification on match runs with a final acceptance.[43] The data provide information on the volume of candidates that would have historically been captured in the allocation table.

Table 2-2: Allocation table for non-DCD multi-organ donors 18 to 69 years old with KDPI of 35-85% showing median appearances

Organ classification and description	Median appearances	Organ classification and description	Median appearances
Liver 1: Status 1A (adult and pediatric); 500NM	0	Pancreas or K/P 1: 0-ABDR mismatch; CPRA ≥ 80%; 250NM	0
Heart 1: Adult Status 1 or Pediatric Status 1A; 500NM	0	Pancreas or K/P 2: CPRA ≥ 80%; 250NM	0
Heart 2: Adult Status 1 or Ped Status 1A; 500NM	0	Heart 5: Adult Status 3 or Pediatric Status 1B; 250NM	3
Liver 2: Status 1B; 500NM	0	Heart 6: Adult Status 3 or Pediatric Status 1B; 250NM	0
Liver 3: Status 1A; HI or PR	0	Pancreas or K/P 3: 0-ABDR mismatch; CPRA ≥ 80%; nation	0
Liver 4: Status 1B; HI or PR	0	Pancreas or K/P 4: 250NM	22
Lung CAS: 41 for O donors; 37 for non-O donors	O donor: 7 Non-O donor: 2	Kidney 6: Medically Urgent; 250NM	0
Heart 3: Adult Status 2; 500NM	9	Kidney 7: 0-ABDR mismatch; CPRA equal to 99%; 250NM	0
Heart 4: Adult Status 2; 500NM	1	Kidney 8: CPRA equal to 99%; 250NM	0
Lung CAS: 35 for O donors; 31 for non-O donors	O donor: 17 Non-O donor: 3	Kidney 9: 0-ABDR mismatch; CPRA equal to 98%; 250NM	0
Kidney 1: 0-ABDR mismatch; CPRA = 100%; 250NM	0	Kidney 10: CPRA equal to 98%; 250NM	0
Kidney 2: CPRA equal to 100%; 250NM	0	Kidney 11: 0-ABDR mismatch; 250NM	0
Kidney 3: 0-ABDR mismatch; CPRA = 100%; nation	0	Kidney 12: 0-ABDR mismatch; CPRA ≥ 80% nation	0
Kidney 4: CPRA equal to 100%; nation	0	Liver 13: MELD/PELD ≥ 33; 150NM	0
Kidney 5: Prior living donor; 250NM	0	Liver 14: MELD/PELD ≥ 33; 150NM	0
Liver 5: MELD/PELD of at least 37; 150NM	0	Liver 15: MELD/PELD ≥ 33; 250NM	0
Liver 6: MELD/PELD of at least 37; 150 NM	0	Liver 16: MELD/PELD ≥ 33; 250NM	0
Liver 7: MELD/PELD of at least 37; 250NM	0	Liver 17: MELD/PELD ≥ 33; 500NM	2
Liver 8: MELD/PELD of at least 37; 250NM	0	Liver 18: MELD/PELD ≥ 33; 500NM	1
Liver 9: MELD/PELD of at least 37; 500NM	1	Liver 19: MELD/PELD ≥ 30; O donor; O or B cand; 150NM	1
Liver 10: MELD/PELD of at least 37; 500NM	1	Liver 20: MELD/PELD ≥ 29; O donor; O cand; 150NM	0
Liver 11: MELD/PELD of at least 37; HI or PR	0	Liver 21: MELD/PELD ≥ 29; non-O donor; any cand; 150NM	1
Liver 12: MELD/PELD of at least 37; HI or PR	0	Liver 22: MELD/PELD ≥ 30; O donor; O or B cand; 250NM	1
Intestine 1: Status 1; 500NM	4	Liver 23: MELD/PELD ≥ 29; O donor; O cand; 250NM	0
Intestine 2: Status 1; 500NM	2	Liver 24: MELD/PELD ≥ 29; non-O donor; any cand; 250NM	1
Intestine 3: Status 1; nation	3	Liver 25: MELD/PELD ≥ 30; O donor; O or B cand; 500NM	4
Intestine 4: Status 1; nation	2	Liver 26: MELD/PELD ≥ 29; O donor; O cand; 500NM	2
Lung CAS: 34 for O donors; 30 for non-O donors	O donor: 28 Non-O donor: 5	Liver 27: MELD/PELD ≥ 29; non-O donor; any cand; 500NM	4
		Kidney 13: 0-ABDR mismatch; CPRA 21%-79%; < 18; nation	0
		Kidney 14: 0-ABDR mismatch; CPRA 0-20%; < 18; nation	0

[43] Median appearances for lung CAS thresholds were derived from a cohort of match runs between September 28, 2023-August 31, 2024, to account for implementation of Lung Continuous Distribution and other lung policy changes. Median appearances for all other classifications were derived from a cohort of match runs between February 1, 2023-December 31, 2023.

Allocation table for DCD multi-organ donors 18 to 69 years old with KDPI less than or equal to 34% showing median appearances

Table 2-3 shows the order of priority for DCD multi-organ donors 18 to 69 with KDPI less than or equal to 34% and **median appearances.** Median appearances is the median number of registrations that appeared in each classification on match runs with a final acceptance.[44] The data provide information on the volume of candidates that would have historically been captured in the allocation table.

Table 2-3: Allocation table for DCD multi-organ donors 18 to 69 years old with KDPI less than or equal to 34% showing median appearances

Organ classification and description	Median appearances	Organ classification and description	Median appearances
Liver 1: Status 1A (adult and pediatric); 500NM	0	Pancreas or K/P 1: 0-ABDR mismatch; CPRA ≥ 80%; 250NM	0
Heart 1: Adult Status 1 or Pediatric Status 1A; 500NM	0	Pancreas or K/P 2: CPRA ≥ 80%; 250NM	0
Heart 2: Adult Status 1 or Ped Status 1A; 500NM	0	Heart 5: Adult Status 3 or Pediatric Status 1B; 250NM	1
Liver 2: Status 1B; 500NM	0	Heart 6: Adult Status 3 or Pediatric Status 1B; 250NM	0
Lung CAS: 41 for O donors; 37 for non-O donors	O donor: 5 Non-O donor: 1	Pancreas or K/P 3: 0-ABDR mismatch; CPRA ≥ 80%; nation	0
Heart 3: Adult Status 2; 500NM	4	Pancreas or K/P 4: 250NM	12
Heart 4: Adult Status 2; 500NM	0	Kidney 6: Registered prior to 18 years old; 250NM	1
Lung CAS: 35 for O donors; 31 for non-O donors	O donor: 11 Non-O donor: 3	Kidney 7: Medically Urgent; 250NM	0
Kidney 1: 0-ABDR mismatch; CPRA = 100%; 250NM	0	Liver 6: MELD/PELD of at least 30; 250NM	1
Kidney 2: CPRA equal to 100%; 250NM	0	Liver 7: MELD/PELD of at least 15; 250NM	46.5
Kidney 3: 0-ABDR mismatch; CPRA = 100%; nation	0	Liver 8: MELD/PELD of at least 15; 250NM	28
Kidney 4: CPRA equal to 100%; nation	0	Liver 9: MELD/PELD of at least 30; 500NM	4
Kidney 5: Prior living donor; 250NM	0	Liver 10: MELD/PELD of at least 15; 500NM	137.5
Liver 3: MELD/PELD of at least 30; 150NM	1	Liver 11: MELD/PELD of at least 15; 500NM	104
Liver 4: MELD/PELD of at least 15; 150NM	51.5	Liver 12: Status 1A; nation	0
Liver 5: MELD/PELD of at least 15; 150NM	28	Liver 13: Status 1B; nation	0
Intestine 1: Status 1; 500NM	NA		
Intestine 2: Status 1; 500NM	NA		
Intestine 3: Status 1; nation	NA		
Intestine 4: Status 1; nation	NA		
Lung CAS: 34 for O donors; 30 for non-O donors	O donor: 20 Non-O donor: 4		

[44] Median appearances for lung CAS thresholds were derived from a cohort of match runs between September 28, 2023-August 31, 2024, to account for implementation of Lung Continuous Distribution and other lung policy changes. Median appearances for all other classifications were derived from a cohort of match runs between February 1, 2023-December 31, 2023.

Allocation table for DCD multi-organ donors 18 to 69 years old with KDPI of 35-85% showing median appearances

Table 2-4 shows the order of priority for DCD multi-organ donors 18 to 69 with KDPI of 35-85% and **median appearances.** Median appearances is the median number of registrations that appeared in each classification on match runs with a final acceptance.[45] The data provide information on the volume of candidates that would have historically been captured in the allocation table.

Table 2-4: Allocation table for DCD multi-organ donors 18 to 69 years old with KDPI of 35-85% showing median appearance

Organ classification and description	Median appearances	Organ classification and description	Median appearances
Liver 1: Status 1A (adult and pediatric); 500NM	0	Pancreas or K/P 1: 0-ABDR mismatch; CPRA ≥ 80%; 250NM	0
Heart 1: Adult Status 1 or Pediatric Status 1A; 500NM	0	Pancreas or K/P 2: CPRA ≥ 80%; 250NM	0
Heart 2: Adult Status 1 or Ped Status 1A; 500NM	0	Heart 5: Adult Status 3 or Pediatric Status 1B; 250NM	1
Liver 2: Status 1B; 500NM	0	Heart 6: Adult Status 3 or Pediatric Status 1B; 250NM	0
Lung CAS: 41 for O donors; 37 for non-O donors	O donor: 5 Non-O donor: 1	Pancreas or K/P 3: 0-ABDR mismatch; CPRA ≥ 80%; nation	0
Heart 3: Adult Status 2; 500NM	4	Pancreas or K/P 4: 250NM	12
Heart 4: Adult Status 2; 500NM	0	Kidney 6: Medically Urgent; 250NM	0
Lung CAS: 35 for O donors; 31 for non-O donors	O donor: 13 Non-O donor: 3	Kidney 7: 0-ABDR mismatch; CPRA equal to 99%; 250NM	0
Kidney 1: 0-ABDR mismatch; CPRA = 100%; 250NM	0	Kidney 8: CPRA = 99%; 250NM	0
Kidney 2: CPRA equal to 100%; 250NM	0	Kidney 9: 0-ABDR mismatch; CPRA = 98%; 250NM	0
Kidney 3: 0-ABDR mismatch; CPRA = 100%; nation	0	Kidney 10: CPRA = 98%; 250NM	0
Kidney 4: CPRA equal to 100%; nation	0	Kidney 11: 0-ABDR mismatch; 250NM	0
Kidney 5: Prior living donor; 250NM	0	Kidney 12: 0-ABDR mismatch, CPRA ≥ 80%; nation	0
Liver 3: MELD/PELD of at least 30; 150NM	1	Kidney 13: 0-ABDR mismatch; CPRA 21-79%; < 18; nation	0
Liver 4: MELD/PELD of at least 15; 150NM	51.5	Kidney 14: 0-ABDR mismatch; CPRA 0-20%; < 18; nation	0
Liver 5: MELD/PELD of at least 15; 150NM	28	Liver 6: MELD/PELD of at least 30; 250NM	1
Intestine 1: Status 1; 500NM	NA	Liver 7: MELD/PELD of at least 15; 250NM	47
Intestine 2: Status 1; 500NM	NA	Liver 8: MELD/PELD of at least 15; 250NM	29
Intestine 3: Status 1; nation	NA	Liver 9: MELD/PELD of at least 30; 500NM	4
Intestine 4: Status 1; nation	NA	Liver 10: MELD/PELD of at least 15; 500NM	150.5
Lung CAS: 34 for O donors; 30 for non-O donors	O donor: 21 Non-O donor: 4	Liver 11: MELD/PELD of at least 15; 500NM	120
		Liver 12: Status 1A; nation	0
		Liver 13: Status 1B; nation	0

[45] Median appearances for lung CAS thresholds were derived from a cohort of match runs between September 28, 2023-August 31, 2024, to account for implementation of Lung Continuous Distribution and other lung policy changes. Median appearances for all other classifications were derived from a cohort of match runs between February 1, 2023-December 31, 2023.

Allocation table for non-DCD multi-organ donors 11 to 17 years old with KDPI less than or equal to 34% showing median appearances

Table 2-5 shows the order of priority for non-DCD multi-organ donors 11 to 17 with KDPI of 0-34% and **median appearances.** Median appearances is the median number of registrations that appeared in each classification on match runs with a final acceptance.[46] The data provide information on the volume of candidates that would have historically been captured in the allocation table.

Table 2-5: Allocation table for non-DCD multi-organ donors 11 to 17 years old with KDPI less than or equal to 34% showing median appearances

Organ classification and description	Median appearances	Organ classification and description	Median appearances
Liver 1: Pediatric Status 1A; 500NM	0	Liver 11: PELD of at least 37; 500NM	2
Liver 2: Adult Status 1A; 500NM	0	Liver 12: Any PELD; 500NM	7
Heart 1: Pediatric Status 1A; 500NM	1	Liver 13: Any PELD; 500NM	3
Heart 2: Pediatric Status 1A; 500NM	0	Liver 14: MELD of at least 37; < 18; 500NM	0
Heart 3: Adult Status 1; 250NM	0	Liver 15: MELD of at least 37; < 18; 500NM	0
Heart 4: Adult Status 1; 250NM	0	Liver 16: MELD of at last 37; HI or PR	0
Liver 3: Pediatric Status 1B; 500NM	0	Liver 17: MELD of at last 37; HI or PR	0
Liver 4: Pediatric Status 1A; HI or PR	0	Lung CAS: 34 for O donors; 30 for non-O donors	O donor: 30 Non-O donor: 5
Liver 5: Adult Status 1B; HI or PR	0	Liver 18: MELD of at least 30; < 18; 500NM	1
Liver 6: Pediatric Status 1B; HI or PR	0	Liver 19: Any MELD; < 18; 500NM	4
Lung CAS: 41 for O donors; 37 for non-O donors	O donor: 8 Non-O donor: 3	Liver 20: Any MELD; < 18; 500NM	2
Heart 5: Adult Status 2; 500NM	1	Liver 21: Pediatric Status 1A; nation	0
Heart 6: Adult Status 2; 500NM	0	Liver 22: Adult Status 1A; nation	1
Heart 7: Pediatric Status 1B; 500NM	2	Liver 23: Pediatric Status 1B; nation	1
Heart 8: Pediatric Status 1B; 500NM	0	Intestine 1: Status 1; 500NM	9
Lung CAS: 35 for O donors; 31 for non-O donors	O donor: 20 Non-O donor: 3	Intestine 2: Status 1; 500NM	8
Kidney 1: 0-ABDR mismatch; CPRA = 100%; 250NM	0	Intestine 3: Status 1; nation	6
Kidney 2: CPRA equal to 100%; 250NM	0	Intestine 4: Status 1; nation	2
Kidney 3: 0-ABDR mismatch; CPRA = 100%; nation	0	Pancreas or K/P 1: 0-ABDR mismatch; CPRA ≥ 80%; 250NM	0
Kidney 4: CPRA equal to 100%; nation	0	Pancreas or K/P 2: CPRA ≥ 80%; 250NM	0
Kidney 5: Prior living donor; 250NM	0	Pancreas or K/P 3: 0-ABDR mismatch; CPRA ≥ 80%; nation	0
Liver 7: PELD of at least 37; 500NM	0	Kidney 6: Registered prior to 18 years old; 250NM	3
Liver 8: PELD of at least 37; 500 NM	0	Pancreas or K/P 4: 250NM	28
Liver 9: PELD of at least 37; HI or PR	0	Kidney 7: Medically Urgent; 250NM	0
Liver 10: PELD of at least 37; HI or PR	0		

[46] Median appearances for lung CAS thresholds were derived from a cohort of match runs between September 28, 2023-August 31, 2024, to account for implementation of Lung Continuous Distribution and other lung policy changes. Median appearances for all other classifications were derived from a cohort of match runs between February 1, 2023-December 31, 2023.

Allocation table for non-DCD multi-organ donors less than 11 years old with KDPI less than or equal to 34% and liver and intestine available showing median appearances

Table 2-6 shows the order of priority for non-DCD multi-organ donors less than 11 years old with KDPI of 0-34% and **median appearances.** Median appearances is the median number of registrations that appeared in each classification on match runs with a final acceptance.[47] The data provide information on the volume of candidates that would have historically been captured in the allocation table.

Table 2-6: Allocation table for non-DCD multi-organ donors less than 11 years old with KDPI less than or equal to 34% and liver and intestine available showing median appearances

Organ classification and description	Median appearances	Organ classification and description	Median appearances
Liver 1: Pediatric Status 1A; 500NM	0	Liver 9: PELD of at least 37; 500NM	2
Liver 2: Pediatric Status 1A; < 12; nation	0	Liver 10: PELD of at least 37; 500NM	0
Liver 3: Pediatric Status 1A; ≥ 12; reg'd for intestine; nation	0	Liver 11: PELD of at least 37; HI or PR	0
Liver 4: Adult Status 1A; 500NM	0	Liver 12: PELD of at least 37; HI or PR	0
Heart 1: Pediatric Status 1A; 500NM	2	Liver 13: PELD of at least 30; 500NM	6
Heart 2: Pediatric Status 1A; 500NM	1	Liver 14: PELD of at least 20; 500NM	2
Heart 3: Adult Status 1; 250NM	0	Liver 15: PELD of at least 20; 500NM	1
Heart 4: Adult Status 1; 250NM	0	Liver 16: Pediatric Status 1B; reg'd for intestine; nation	0
Liver 5: Pediatric Status 1B; 500NM	2	Liver 17: PELD of at least 30; reg'd for intestine; nation	1
Liver 6: Pediatric Status 1A; at least 12; HI or PR	0	Liver 18: PELD of at least 20; reg'd for intestine; nation	1
Liver 7: Adult Status 1A; HI or PR	0	Liver 19: PELD of at least 20; reg'd for intestine; nation	0
Liver 8: Pediatric Status 1B; HI or PR	0	Liver 20: Any PELD; 500NM	13
Lung CAS: 41 for O donors; 37 for non-O donors	O donor: 6 Non-O donor: 4	Liver 21: Any PELD; 500NM	3
Heart 5: Adult Status 2; 500NM	1	Liver 22: MELD of at least 37; < 18; 500NM	1
Heart 6: Adult Status 2; 500NM	0	Liver 23: MELD of at least 37; < 18; 500NM	0
Heart 7: Pediatric Status 1B; 500NM	3	Liver 24: MELD of at least 37; < 18 HI or PR	0
Heart 8: Pediatric Status 1B; 500NM	0	Liver 25: MELD of at least 37; < 18 HI or PR	0
Lung CAS: 35 for O donors; 31 for non-O donors	O donor: 0 Non-O donor: 0	Lung CAS: 34 for O donors; 30 for non-O donors	O donor: 2 Non-O donor: 0
Kidney 1: 0-ABDR mismatch; CPRA = 100%; 250NM	0	Liver 26: MELD of at least 30; < 18; 500NM	2
Kidney 2: CPRA equal to 100%; 250NM	0	Liver 27: Any MELD; < 18; 500NM	4
Kidney 3: 0-ABDR mismatch; CPRA = 100%; nation	0	Liver 28: Any MELD; < 18; 500NM	1
Kidney 4: CPRA equal to 100%; nation	0	Kidney 6: Registered prior to 18 years old; 250NM	4.5
Kidney 5: Prior living donor; 250NM	0	Pancreas or K/P 1: 0-ABDR mismatch; CPRA ≥ 80%; 250NM	0
Intestine 1: Status 1; 500NM	10.5	Pancreas or K/P 2: CPRA ≥ 80%; 250NM	0
Intestine 2: Status 1; 500NM	6.5	Pancreas or K/P 3: 0-ABDR mismatch; CPRA ≥ 80%; nation	0
Intestine 3: Status 1; nation	6.5	Pancreas or K/P 4: 250NM	8
Intestine 4: Status 1; nation	5.5	Kidney 7: Medically Urgent; 250NM	0

[47] Median appearances for lung CAS thresholds were derived from a cohort of match runs between September 28, 2023-August 31, 2024, to account for implementation of Lung Continuous Distribution and other lung policy changes. Median appearances for all other classifications were derived from a cohort of match runs between February 1, 2023-December 31, 2023.

Allocation table for non-DCD multi-organ donors less than 11 years old with KDPI of 35-85% and liver and intestine available showing median appearances

Table 2-7 shows the order of priority for non-DCD multi-organ donors less than 11 years old with KDPI of 35-85% and **median appearances.** Median appearances is the median number of registrations that appeared in each classification on match runs with a final acceptance.[48] The data provide information on the volume of candidates that would have historically been captured in the allocation table.

Table 2-7: Allocation table for non-DCD multi-organ donors less than 11 years old with KDPI of 35-85% and liver and intestine available showing median appearances

Organ classification and description	Median appearances	Organ classification and description	Median appearances
Liver 1: Pediatric Status 1A; 500NM	0	Liver 9: PELD of at least 37; 500NM	2
Liver 2: Pediatric Status 1A; < 12; nation	0	Liver 10: PELD of at least 37; 500NM	0
Liver 3: Pediatric Status 1A; ≥ 12; reg'd for intestine; nation	0	Liver 11: PELD of at least 37; HI or PR	0
Liver 4: Adult Status 1A; 500NM	0	Liver 12: PELD of at least 37; HI or PR	0
Heart 1: Pediatric Status 1A; 500NM	9.5	Liver 13: PELD of at least 30; 500NM	5
Heart 2: Pediatric Status 1A; 500NM	1	Liver 14: PELD of at least 20; 500NM	3
Heart 3: Adult Status 1; 250NM	0	Liver 15: PELD of at least 20; 500NM	4
Heart 4: Adult Status 1; 250NM	0	Liver 16: Pediatric Status 1B; reg'd for intestine; nation	0
Liver 5: Pediatric Status 1B; 500NM	2	Liver 17: PELD of at least 30; reg'd for intestine; nation	1
Liver 6: Pediatric Status 1A; at least 12; HI or PR	0	Liver 18: PELD of at least 20; reg'd for intestine; nation	2.5
Liver 7: Adult Status 1A; HI or PR	0	Liver 19: PELD of at least 20; reg'd for intestine; nation	2
Liver 8: Pediatric Status 1B; HI or PR	0	Liver 20: Any PELD; 500NM	10
Lung CAS: 41 for O donors; 37 for non-O donors	O donor: 2 Non- O donor: 1	Liver 21: Any PELD; 500NM	3
Heart 5: Adult Status 2; 500NM	0	Liver 22: MELD of at least 37; < 18; 500NM	1
Heart 6: Adult Status 2; 500NM	0	Liver 23: MELD of at least 37; < 18; 500NM	0
Heart 7: Pediatric Status 1B; 500NM	2	Liver 24: MELD of at least 37; < 18 HI or PR	0
Heart 8: Pediatric Status 1B; 500NM	0	Liver 25: MELD of at least 37; < 18 HI or PR	0
Lung CAS: 35 for O donors; 31 for non-O donors	O donor: 0 Non-O donor: 0	Lung CAS: 34 for O donors; 30 for non-O donors	O donor: 0 Non-O donor: 0
Kidney 1: 0-ABDR mismatch; CPRA = 100%; 250NM	0	Liver 26: MELD of at least 30; < 18; 500NM	0
Kidney 2: CPRA equal to 100%; 250NM	0	Liver 27: Any MELD; < 18; 500NM	2
Kidney 3: 0-ABDR mismatch; CPRA = 100%; nation	0	Liver 28: Any MELD; < 18; 500NM	1
Kidney 4: CPRA equal to 100%; nation	0	Pancreas or K/P 1: 0-ABDR mismatch; CPRA ≥ 80%; 250NM	0
Kidney 5: Prior living donor; 250NM	0	Pancreas or K/P 2: CPRA ≥ 80%; 250NM	0
Intestine 1: Status 1; 500NM	6	Pancreas or K/P 3: 0-ABDR mismatch; CPRA ≥ 80%; nation	0
Intestine 2: Status 1; 500NM	2	Pancreas or K/P 4: 250NM	9
Intestine 3: Status 1; nation	4	Kidney 6: Medically Urgent; 250NM	0
Intestine 4: Status 1; nation	2		

Table continues on next page

[48] Median appearances for lung CAS thresholds were derived from a cohort of match runs between September 28, 2023-August 31, 2024, to account for implementation of Lung Continuous Distribution and other lung policy changes. Median appearances for all other classifications were derived from a cohort of match runs between February 1, 2023-December 31, 2023.

Organ classification and description	Median appearances
Kidney 7: 0-ABDR mismatch; CPRA equal to 99%; 250NM	0
Kidney 8: CPRA = 99%; 250NM	0
Kidney 9: 0-ABDR mismatch; CPRA = 98%; 250NM	0
Kidney 10: CPRA = 98%; 250NM	0
Kidney 11: 0-ABDR mismatch; 250NM	0
Kidney 12: 0-ABDR mismatch, CPRA ≥ 80%; nation	0
Kidney 13: 0-ABDR mismatch; CPRA 21-79%; < 18; nation	0
Kidney 14: 0-ABDR mismatch; CPRA 0-20%; < 18; nation	0

Policy Language

Proposed new language is underlined (example) and language that is proposed for removal is struck through (~~example~~). Heading numbers, table and figure captions, and cross-references affected by the numbering of these policies will be updated as necessary.

1.2: Definitions

Deceased multi-organ donor
A deceased donor from whom at least two different organs are recovered for the purpose of transplantation.

Multi-organ allocation plan
A plan, generated within the OPTN Computer System, that describes the order in which organs from a deceased multi-organ donor covered by a multi-organ allocation table in *Policy 5.10: Allocation of Organs from Deceased Multi-Organ Donors* must be offered to potential transplant recipients.

Primary potential transplant recipient
~~The first candidate according to match run sequence for whom an organ has been accepted.~~
The highest priority potential transplant recipient on a match run.

5.4.B Order of Allocation

OPOs must allocate organs from deceased multi-organ donors in accordance with *Policy 5.10: Allocation of Organs from Deceased Multi-Organ Donors.*

The process to allocate deceased donor organs occurs with these steps:

1. The match system eliminates candidates who cannot accept the deceased donor based on size or blood type.
2. The match system ranks candidates according to the allocation sequences in the organ allocation policies.
3. OPOs must ~~first~~ offer organs to single- and multi-organ potential transplant recipients (PTRs) in the order that the PTRs appear on a match run.
4. If no transplant program on the initial match run accepts the organ, the host OPO may give transplant programs the opportunity to update candidates' data with the OPTN. The host OPO must re-execute the match run to allocate the organ.
5. Extra vessels allocated with an organ but not required for its transplant can be shared according to OPTN *Policy 16.6.A: Extra Vessels Use and Sharing*.
6. Members may export deceased donor organs to hospitals in foreign countries only after offering these organs to all PTRs on the match run. Members must submit the Organ Export Verification Form to the OPTN prior to exporting deceased donor organs.

5.6.D Effect of Acceptance

~~When a transplant hospital accepts an OPO's organ offer without conditions, this acceptance binds the transplant hospital and OPO unless they mutually agree on an alternative allocation of the organ.~~

~~If an organ has been accepted by a transplant program for a primary potential transplant recipient, the organ is not required to be offered according to *Policy 5.10: Allocation of Multi-Organ Combinations.*~~

If an organ has been accepted by a transplant program for a primary potential transplant recipient, this acceptance binds the transplant hospital and OPO unless they mutually agree on an alternative allocation of the organ.

~~5.10 Allocation of Multi-Organ Combinations~~

~~5.10.A Allocation of Heart-Lungs~~

~~Heart-lung combinations are allocated according to OPTN Policy 6.6.F: Allocation of Heart-Lungs.~~

~~5.10.B Allocation of Liver-Kidneys~~

~~Liver-kidney combinations are allocated according to OPTN Policy 9.9: Liver-Kidney Allocation.~~

~~5.10.C Allocation of Kidney-Pancreas~~

~~Kidney-pancreas combinations are allocated according to OPTN Policy 11: Allocation of Pancreas, Kidney-Pancreas, and Islets.~~

~~5.10.D Allocation of Liver-Intestines~~

~~Liver-intestine combinations are allocated according to OPTN Policy 9: Allocation of Livers and Liver-Intestines.~~

~~5.10.E Allocation of Heart-Kidneys~~

~~When an OPO is offering a heart, and a kidney is also available from the same deceased donor, then the OPO must offer the kidney to a potential transplant recipient (PTR) who is registered for a heart and a kidney at the same transplant hospital, and who meets either of the following criteria:~~

- ~~PTR is registered at a transplant hospital at or within 500 NM of the donor hospital and is any active pediatric status, or~~
- ~~PTR is registered at a transplant hospital at or within 500 NM of the donor hospital and heart adult status 1, 2, 3, 4, or 5, and meets the eligibility criteria established in *Table 5-4: Medical Eligibility Criteria for Heart-Kidney Allocation*~~

~~If a host OPO is offering a kidney and a heart from the same deceased donor, then before allocating the kidney to kidney-alone candidates, the host OPO must offer the kidney with the heart to candidates who meet either of the eligibility criteria described in OPTN Policy 5.10.E.~~

~~Table 5-4: Medical Eligibility Criteria for Heart-Kidney Allocation~~

~~If the candidate's transplant nephrologist confirms a diagnosis of:~~	**~~Then the transplant program must report to the OPTN and document in the candidate's medical record:~~**
~~Chronic kidney disease (CKD) with a measured or estimated glomerular filtration rate (GFR) less than or equal to 60 mL/min for greater than 90 consecutive days~~	~~At least *one* of the following:~~ ~~• That the candidate has begun regularly administered dialysis as an end-stage renal disease (ESRD) patient in a hospital based, independent non-hospital based, or home setting.~~ ~~• At the time of registration on the kidney waiting list, that the candidate's most recent measured or estimated creatinine clearance (CrCl) or GFR is less than or equal to 30 mL/min.~~ ~~• On a date after registration on the kidney waiting list, that the candidate's~~

	measured or estimated CrCl or GFR is less than or equal to 30 mL/min.
Sustained acute kidney injury	At least one of the following, or a combination of both of the following, for the last 6 weeks: • That the candidate has been on dialysis at least once every 7 days. • That the candidate has a measured or estimated CrCl or GFR less than or equal to 25 mL/min at least once every 7 days. If the candidate's eligibility is not confirmed at least once every seven days for the last 6 weeks, the candidate is not eligible to receive a heart and a kidney from the same donor.

5.10.F Allocation of Lung-Kidneys

When an OPO is offering a lung, and a kidney is also available from the same deceased donor, then the OPO must offer the kidney to a potential transplant recipient (PTR) who is registered for a lung and a kidney at the same transplant hospital, and who meets either of the following criteria:

- PTR was less than 18 years old when registered on the lung waiting list, or
- PTR has a Lung Composite Allocation Score of 25[49] or greater, and meets eligibility according to *Table 5-5: Medical Eligibility Criteria for Lung-Kidney Allocation*

If a host OPO is offering a kidney and a lung from the same deceased donor, then before allocating the kidney to kidney-alone candidates, the host OPO must offer the kidney with the lung to candidates who meet either of the eligibility criteria described in OPTN Policy 5.10.F.

Table 5-5: Medical Eligibility Criteria for Lung-Kidney Allocation

If the candidate's transplant nephrologist confirms a diagnosis of:	Then the transplant program must report to the OPTN and document in the candidate's medical record:
Chronic kidney disease (CKD) with a measured or estimated glomerular filtration rate (GFR) less than or equal to 60 mL/min for greater than 90 consecutive days	At least *one* of the following: • That the candidate has begun regularly administered dialysis as an end-stage renal disease (ESRD) patient in a hospital based, independent non-hospital based, or home setting. • At the time of registration on the kidney waiting list, that the candidate's most recent measured or estimated creatinine clearance (CrCl) or GFR is less than or equal to 30 mL/min.

[49] When this proposal was approved by the OPTN Board of Directors on June 27, 2022, this policy required a Lung Composite Allocation Score of 28 or greater. A subsequent proposal approved by the OPTN Board of Directors on December 5, 2022, changed the requirement to a Lung Composite Allocation Score of 25 or greater. See: https://optn.transplant.hrsa.gov/media/ai4npr5x/policy-notice_mot-for-cd_lung.pdf.

~~If the candidate's transplant nephrologist confirms a diagnosis of:~~	~~Then the transplant program must report to the OPTN and document in the candidate's medical record:~~
	• ~~On a date after registration on the kidney waiting list, that the candidate's measured or estimated CrCl or GFR is less than or equal to 30 mL/min.~~
~~Sustained acute kidney injury~~	~~At least one of the following, or a combination of both of the following, for the last 6 weeks:~~ • ~~That the candidate has been on dialysis at least once every 7 days.~~ • ~~That the candidate has a measured or estimated CrCl or GFR less than or equal to 25 mL/min at least once every 7 days. If the candidate's eligibility is not confirmed at least once every seven days for the last 6 weeks, the candidate is not eligible to receive a lung and a kidney from the same donor.~~

~~5.10.G Allocation of Heart-Liver and Lung-Liver~~

~~When an OPO is offering a heart or lung, and a liver is also available from the same deceased donor, PTRs who meet the criteria in *Table 5-6: When Offering a Heart or Lung and Second Organ Is a Liver* must be offered the liver. When an OPO is offering a heart or lung and two PTRs meet the criteria in *Table 5-6*, the OPO has the discretion to offer the liver to either PTR.~~

~~Table 5-6: When Offering a Heart or Lung and Second Organ Is a Liver~~

	~~The OPO must offer the liver if the PTR meets the following criteria:~~
~~Heart~~	• ~~Registered at a transplant hospital at or within 500 NM of the donor hospital~~ • ~~Heart Adult Status 1, 2, 3 or any active pediatric status~~
~~Lung~~	~~Has a Lung Composite Allocation Score of 25 or greater[50]~~

5.10: Allocation of Organs from Deceased Multi-Organ Donors

5.10.A: Allocation Order

The OPO must allocate organs from deceased multi-organ donors to single-organ and qualifying multi-organ candidates according to the multi-organ allocation tables in *Policy 5.10: Allocation of Organs from Deceased Multi-Organ Donors*. For deceased donors not covered by a multi-organ allocation table, the OPO may determine the order in which to make organ offers across match runs.

[50] When this proposal was approved by the OPTN Board of Directors on June 27, 2022, this policy required a Lung Composite Allocation Score of 28 or greater. A subsequent proposal approved by the OPTN Board of Directors on December 5, 2022, changed the requirement to a Lung Composite Allocation Score of 25 or greater. See: https://optn.transplant.hrsa.gov/media/ai4npr5x/policy-notice_mot-for-cd_lung.pdf.

5.10.B: Allocation Process

The OPO must allocate organs from deceased multi-organ donors according to the process below:

1. The OPO must determine which organs may be recovered and must execute match runs for the organs to be recovered for the purpose of transplantation
    a. For donors with heart and lungs available, the OPO must execute the heart-lung and lung match runs at the same time
    b. For donors with liver and intestine available, the OPO must execute the liver and the intestine match runs at the same time
    c. For donors with kidney(s) and pancreas available, the OPO must execute the pancreas/kidney-pancreas and kidney match runs
2. Prior to making organ offers to primary potential transplant recipients, the OPO must generate a multi-organ allocation plan.
3. The OPO must make organ offers according to the multi-organ allocation plan.
4. If the OPO has made organ offers to all potential transplant recipients covered by a multi-organ allocation table in *Policy 5.10: Allocation of Organs from Deceased Multi-Organ Donors*, and organ(s) have not been accepted, the OPO may determine the order in which to make organ offers across match runs.
5. If an organ becomes eligible for allocation according to any of the policies below, the OPO may allocate the eligible organ according to these policies and must continue allocating other organs according to the multi-organ allocation table in *Policy 5.10: Allocation of Organs from Deceased Multi-Organ Donors*.
    - *Policy 5.9: Released Organs*
    - *Policy 9.10: Expedited Placement of Livers*
    - *Policy 11.6: Facilitated Pancreas Allocation*

5.10.C: Re-executing Multi-Organ Allocation Plans

If a match run is re-executed after the OPO has made an organ offer to a primary potential transplant recipient, the OPO must re-execute the multi-organ allocation plan prior to making offers from the new match. The OPO must make subsequent organ offers according to the new multi-organ allocation plan, excluding organs previously accepted according to OPTN *Policy 5.6.D Effect of Acceptance*.

If an additional organ becomes available for donation after the OPO has made an organ offer to a primary potential transplant recipient, the OPO must execute the match run for the additional organ, re-execute the multi-organ allocation plan and make subsequent organ offers according to the new multi-organ allocation plan, excluding organs previously accepted according to OPTN *Policy 5.6.D Effect of Acceptance*.

5.10.D: Multi-Organ Offers

Policy 5.10.D applies to all multi-organ offers, including multi-organ offers not covered by a multi-organ allocation table in *Policy 5.10: Allocation of Organs from Deceased Multi-Organ Donors*.

Subject to the medical eligibility criteria in *Policy 5.10.E,* OPOs must make offers to candidates who are registered for more than one organ in accordance with *Table 5-4*.

OPOs must not offer heart, lung, or liver from the match runs specified in *Table 5-4.*

On the VCA match runs, OPOs must not offer organs other than covered VCA.

Table 5-4: Multi-Organ Offers

From this match run:	OPOs must make multi-organ offers to PTRs who are also registered for:	OPOs must not offer heart, lung, or liver from certain match runs:	Certain candidates must meet medical eligibility criteria:
Heart or Heart-Lung	Lung, liver, intestine, kidney, pancreas, covered VCA	Not applicable	Adult heart-kidney (*Policy 5.10.E)*
Lung	Heart, liver, intestine, kidney, pancreas, covered VCA	Not applicable	Adult lung-kidney candidates (*Policy 5.10.E)*
Liver	Heart, lung, intestine, kidney, pancreas, covered VCA	Not applicable	Adult liver-kidney candidates (*Policy 5.10.E)*
Intestine	Kidney, pancreas, covered VCA	OPOs must not offer heart, lung, or liver	Not applicable
Kidney	Intestine, covered VCA	OPOs must not offer heart, lung, or liver	Not applicable
Pancreas/Kidney-Pancreas	Intestine, covered VCA	OPOs must not offer heart, lung, or liver	Not applicable

5.10.E: Medical Eligibility for Multi-Organ Offers

Policy 5.10.E applies to all multi-organ offers, including multi-organ offers not covered by a multi-organ allocation table in *Policy 5.10: Allocation of Organs from Deceased Multi-Organ Donors*.

OPOs must not offer organs for which the candidate does not meet medical eligibility criteria in *Table 5-5: Medical Eligibility Criteria for Adult Heart-Kidney and Adult Lung-Kidney Allocation* or *Table 5-6: Medical Eligibility for Adult Liver-Kidney Allocation*.

Pediatric candidates are not required to meet the medical eligibility criteria in *Table 5-5: Medical Eligibility Criteria for Adult Heart-Kidney and Adult Lung-Kidney Allocation* or *Table 5-6: Medical Eligibility for Adult Liver-Kidney Allocation*.

If a multi-organ candidate meets the medical eligibility criteria, but one or more of the organs the candidate is registered for are not available, the OPO must offer the available organ(s).

Adult heart-kidney candidates, including those registered for additional organ(s), must satisfy *Table 5-5: Medical Eligibility Criteria for Heart-Kidney and Lung-Kidney Allocation.*

Adult lung-kidney candidates, including those registered for additional organ(s), must satisfy *Table 5-5: Medical Eligibility Criteria for Heart-Kidney and Lung-Kidney Allocation.*

Adult liver-kidney candidates, including those registered for additional organ(s), must satisfy *Table 5-6: Medical Eligibility for Liver-Kidney Allocation.*

Adult heart-liver candidates, including those registered for additional organ(s) who are also registered for a kidney are eligible for the kidney if they satisfy medical eligibility criteria in either *Table 5-5: Medical Eligibility Criteria for Heart-Kidney and Lung Kidney Allocation* or *Table 5-6: Medical Eligibility for Liver-Kidney Allocation.*

Adult lung-liver candidates, including those registered for additional organ(s) who are also registered for a kidney are eligible for the kidney if they satisfy medical eligibility criteria in either *Table 5-5: Medical Eligibility Criteria for Heart-Kidney and Lung-Kidney Allocation* or *Table 5-6: Medical Eligibility for Liver-Kidney Allocation.*

Table 5-5: Medical Eligibility Criteria for Adult Heart-Kidney and Lung-Kidney Allocation

If the candidate's transplant nephrologist confirms a diagnosis of:	Then the transplant program must report to the OPTN and document in the candidate's medical record:
Chronic kidney disease (CKD) with a measured or estimated glomerular filtration rate (GFR) less than or equal to 60 mL/min for greater than 90 consecutive days	At least *one* of the following: • That the candidate has begun regularly administered dialysis as an end-stage renal disease (ESRD) patient in a hospital based, independent non-hospital based, or home setting. • At the time of registration on the kidney waiting list, that the candidate's most recent measured or estimated creatinine clearance (CrCl) or GFR is less than or equal to 30 mL/min. • On a date after registration on the kidney waiting list, that the candidate's measured or estimated CrCl or GFR is less than or equal to 30 mL/min.
Sustained acute kidney injury	At least one of the following, or a combination of both of the following, for the last 6 weeks: • That the candidate has been on dialysis at least once every 7 days. • That the candidate has a measured or estimated CrCl or GFR less than or equal to 25 mL/min at least once every 7 days. If the candidate's eligibility is not confirmed at least once every seven days for the last 6 weeks, the candidate is not eligible to receive a heart and a kidney or a lung and a kidney from the same donor.

Table 5-6: Medical Eligibility Criteria for Adult Liver-Kidney Allocation

If the candidate's transplant nephrologist confirms a diagnosis of:	Then the transplant program must report to the OPTN and document in the candidate's medical record:
Chronic kidney disease (CKD) with a measured or estimated glomerular filtration rate (GFR) less than or equal to 60 mL/min for greater than 90 consecutive days	At least *one* of the following: • That the candidate has begun regularly administered dialysis as an end-stage renal disease (ESRD) patient in a hospital based, independent non-hospital based, or home setting. • At the time of registration on the kidney waiting list, that the candidate's most recent measured or estimated creatinine clearance (CrCl) or GFR is less than or equal to 30 mL/min. • On a date after registration on the kidney waiting list, that the candidate's measured or estimated CrCl or GFR is less than or equal to 30 mL/min.
Sustained acute kidney injury	At least one of the following, or a combination of both of the following, for the last 6 weeks: • That the candidate has been on dialysis at least once every 7 days. • That the candidate has a measured or estimated CrCl or GFR less than or equal to 25 mL/min at least once every 7 days. If the candidate's eligibility is not confirmed at least once every seven days for the last 6 weeks, the candidate is not eligible to receive a liver and a kidney from the same donor.
Metabolic disease	A diagnosis of at least *one* of the following: • Hyperoxaluria • Atypical hemolytic uremic syndrome (HUS) from mutations in factor H or factor I • Familial non-neuropathic systemic amyloidosis • Methylmalonic aciduria

5.10.F: Allocation of organs from non-DCD multi-organ donors 18 to 69 years old with KDPI less than or equal to 34%

Organs from non-DCD multi-organ donors 18 to 69 years old with KDPI less than or equal to 34% are allocated to candidates according to Table 5-7.

Table 5-7 incorporates orders of priority from the following policy tables:

1. Liver Classifications are from *OPTN Policy Table 9-11: Allocation of Livers from Non-DCD Deceased Donors at Least 18 Years Old and Less than 70 Years Old*
2. Heart Classifications are from *OPTN Policy Table 6-7: Allocation of Hearts from Deceased Donors At Least 18 Years Old*
3. Lung composite allocation score ranges are based on *OPTN Policy 10.1: Lung Composite Allocation Score*
4. Kidney Classifications are from *OPTN Policy Table 8-7: Allocation of Kidneys from Deceased Donors with KDPI Less Than or Equal To 20%* and *OPTN Policy Table 8-8: Allocation of Kidneys from Deceased Donors with KDPI Scores Greater Than 20% but Less Than 35%*
5. Intestine Classifications are from *OPTN Policy Table 7-1: Allocation of Intestines*
6. Pancreas and Kidney-Pancreas Classifications in this table are from *OPTN Policy Table 11-5: Allocation of Kidneys and Pancreas from Deceased Donors 50 Years Old and Less with a BMI Less Than or Equal To 30 kg/m2* and *OPTN Policy Table 11-6: Allocation of Kidneys and Pancreas from Deceased Donors More Than 50 Years Old or with a BMI Greater Than 30 kg/m2*

Table 5-7: Allocation of organs from non-DCD multi-organ donors 18 to 69 years old with KDPI less than or equal to 34%

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	1	Status 1A; any donor blood type; any candidate blood type	500NM
Heart	1	Adult Status 1 or Pediatric Status 1A; primary blood type match with the donor	500NM
Heart	2	Adult Status 1 or Pediatric Status 1A; secondary blood type match with the donor	500NM
Liver	2	Status 1B; any donor blood type; any candidate blood type	500NM
Liver	3	Status 1A; any donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	4	Status 1B; any donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Lung	Lung CAS greater than or equal to 41 for O blood type donors; Lung CAS greater than or equal to 37 for non-O blood type donors		

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Heart	3	Adult Status 2; primary blood type match with the donor	500NM
Heart	4	Adult Status 2; secondary blood type match with the donor	500NM
Lung	Lung CAS greater than or equal to 35 for O blood type donors; Lung CAS greater than or equal to 31 for non-O blood type donors		
Kidney	1	0-ABDR mismatch; CPRA equal to 100%; blood type identical or permissible; any donor blood type	250NM
Kidney	2	CPRA equal to 100%; blood type identical or permissible; any donor blood type	250NM
Kidney	3	0-ABDR mismatch; CPRA equal to 100%; blood type identical or permissible; any donor blood type	Nation
Kidney	4	CPRA equal to 100%; blood type identical or permissible; any donor blood type	Nation
Kidney	5	Prior living donor; blood type identical or permissible	250NM
Liver	5	MELD or PELD of at least 37; O donor blood type; O or B candidate blood type	150NM
Liver	6	MELD or PELD of at least 37; non-O donor blood type; any candidate blood type	150NM
Liver	7	MELD or PELD of at least 37; O donor blood type; O or B candidate blood type	250NM
Liver	8	MELD or PELD of at least 37; non-O donor blood type; any candidate blood type	250NM
Liver	9	MELD or PELD of at least 37; O donor blood type; O or B candidate blood type	500NM
Liver	10	MELD or PELD of at least 37; non-O donor blood type; any candidate blood type	500NM
Liver	11	MELD or PELD of at least 37; O donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	12	MELD or PELD of at least 37; non-O donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Intestine	1	Status 1; blood type identical to the donor	500NM
Intestine	2	Status 1; blood type compatible with the donor	500NM
Intestine	3	Status 1; blood type identical to the donor	Nation
Intestine	4	Status 1; blood type compatible with the donor	Nation
Lung	Lung CAS greater than or equal to 34 for O blood type donors; Lung CAS greater than or equal to 30 for non-O blood type donors		
Pancreas and Kidney-Pancreas	1	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	250NM
Pancreas and Kidney-Pancreas	2	Either pancreas or kidney-pancreas candidates; CPRA greater than or equal to 80%	250NM
Heart	5	Adult Status 3 or Pediatric Status 1B; primary blood type match with the donor	250NM
Heart	6	Adult Status 3 or Pediatric Status 1B; secondary blood type match with the donor	250NM
Pancreas and Kidney-Pancreas	3	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	Nation
Pancreas and Kidney-Pancreas	4	Pancreas or kidney-pancreas candidates	250NM
Kidney	6	Registered prior to 18 years old; blood type identical or permissible; any donor blood type	250NM
Kidney	7	Medically urgent; any donor blood type	250NM
Kidney	8	0-ABDR mismatch; CPRA equal to 99%; blood type identical or permissible; any donor blood type	250NM
Kidney	9	CPRA equal to 99%; blood type identical or permissible; any donor blood type	250NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Kidney	10	0-ABDR mismatch; CPRA equal to 98%; blood type identical or permissible; any donor blood type	250NM
Kidney	11	CPRA equal to 98%; blood type identical or permissible; any donor blood type	250NM
Liver	13	MELD or PELD of at least 33; O donor blood type; O or B candidate blood type	150NM
Liver	14	MELD or PELD of at least 33; non-O donor blood type; any candidate blood type	150NM
Liver	15	MELD or PELD of at least 33; O donor blood type; O or B candidate blood type	250NM
Liver	16	MELD or PELD of at least 33; non-O donor blood type; any candidate blood type	250NM
Liver	17	MELD or PELD of at least 33; O donor blood type; O or B candidate blood type	500NM
Liver	18	MELD or PELD of at least 33; non-O donor blood type; any candidate blood type	500NM
Liver	19	MELD or PELD of at least 30; O donor blood type; O or B candidate blood type	150NM
Liver	20	MELD or PELD of at least 29; O donor blood type; O candidate blood type	150NM
Liver	21	MELD or PELD of at least 29; non-O donor blood type; any candidate blood type	150NM
Liver	22	MELD or PELD of at least 30; O donor blood type; O or B candidate blood type	250NM
Liver	23	MELD or PELD of at least 29; O donor blood type; O candidate blood type	250NM
Liver	24	MELD or PELD of at least 29; non-O donor blood type; any candidate blood type	250NM
Liver	25	MELD or PELD of at least 30; O donor blood type; O or B candidate blood type	500NM
Liver	26	MELD or PELD of at least 29; O donor blood type; O candidate blood type	500NM
Liver	27	MELD or PELD of at least 29; non-O donor blood type; any candidate blood type	500NM

5.10.G: Allocation of organs from non-DCD multi-organ donors 18 to 69 years old with KDPI greater than or equal to 35% but less than or equal to 85%

Organs from non-DCD multi-organ donors 18 to 69 years old with KDPI greater than or equal to 35% but less than or equal to 85% are allocated to candidates according to Table 5-8.

Table 5-8 incorporates orders of priority from the following policy tables:

1. Liver Classifications are from *OPTN Policy Table 9-11: Allocation of Livers from Non-DCD Deceased Donors at Least 18 Years Old and Less than 70 Years Old*
2. Heart Classifications are from *OPTN Policy Table 6-7: Allocation of Hearts from Deceased Donors At Least 18 Years Old*
3. Lung composite allocation score ranges are based on *OPTN Policy 10.1: Lung Composite Allocation Score*
4. Kidney Classifications are from *OPTN Policy Table 8-9: Allocation of Kidneys from Deceased Donors with KDPI Greater Than or Equal To 35% and Less Than or Equal To 85%*
5. Intestine Classifications are from *OPTN Policy Table 7-1: Allocation of Intestines*
6. Pancreas and Kidney-Pancreas Classifications in this table are from *OPTN Policy Table 11-5: Allocation of Kidneys and Pancreas from Deceased Donors 50 Years Old and Less with a BMI Less Than or Equal To 30 kg/m2* and *OPTN Policy Table 11-6: Allocation of Kidneys and Pancreas from Deceased Donors More Than 50 Years Old or with a BMI Greater Than 30 kg/m2*

Table 5-8: Allocation of organs from non-DCD multi-organ donors 18 to 69 years old with KDPI greater than or equal to 35% but less than or equal to 85%

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	1	Status 1A; any donor blood type; any candidate blood type	500NM
Heart	1	Adult Status 1 or Pediatric Status 1A; primary blood type match with the donor	500NM
Heart	2	Adult Status 1 or Pediatric Status 1A; secondary blood type match with the donor	500NM
Liver	2	Status 1B; any donor blood type; any candidate blood type	500NM
Liver	3	Status 1A; any donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	4	Status 1B; any donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Lung	Lung CAS greater than or equal to 41 for O blood type donors; Lung CAS greater than or equal to 37 for non-O blood type donors		

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Heart	3	Adult Status 2; primary blood type match with the donor	500NM
Heart	4	Adult Status 2; secondary blood type match with the donor	500NM
Lung	Lung CAS greater than or equal to 35 for O blood type donors; Lung CAS greater than or equal to 31 for non-O blood type donors		
Kidney	1	0-ABDR mismatch; CPRA equal to 100%; blood type identical or permissible; any donor blood type	250NM
Kidney	2	CPRA equal to 100%; blood type identical or permissible; any donor blood type	250NM
Kidney	3	0-ABDR mismatch; CPRA equal to 100%; blood type identical or permissible; any donor blood type	Nation
Kidney	4	CPRA equal to 100%; blood type identical or permissible; any donor blood type	Nation
Kidney	5	Prior living donor; blood type identical or permissible	250NM
Liver	5	MELD or PELD of at least 37; O donor blood type; O or B candidate blood type	150NM
Liver	6	MELD or PELD of at least 37; non-O donor blood type; any candidate blood type	150NM
Liver	7	MELD or PELD of at least 37; O donor blood type; O or B candidate blood type	250NM
Liver	8	MELD or PELD of at least 37; non-O donor blood type; any candidate blood type	250NM
Liver	9	MELD or PELD of at least 37; O donor blood type; O or B candidate blood type	500NM
Liver	10	MELD or PELD of at least 37; non-O donor blood type; any candidate blood type	500NM
Liver	11	MELD or PELD of at least 37; O donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
			1,100NM and candidate is registered in Puerto Rico
Liver	12	MELD or PELD of at least 37; non-O donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Intestine	1	Status 1; blood type identical to the donor	500NM
Intestine	2	Status 1; blood type compatible with the donor	500NM
Intestine	3	Status 1; blood type identical to the donor	Nation
Intestine	4	Status 1; blood type compatible with the donor	Nation
Lung	Lung CAS greater than or equal to 34 for O blood type donors; Lung CAS greater than or equal to 30 for non-O blood type donors		
Pancreas or Kidney-Pancreas	1	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	250NM
Pancreas or Kidney-Pancreas	2	Either pancreas or kidney-pancreas candidates; CPRA greater than or equal to 80%	250NM
Heart	5	Adult Status 3 or Pediatric Status 1B; primary blood type match with the donor	250NM
Heart	6	Adult Status 3 or Pediatric Status 1B; secondary blood type match with the donor	250NM
Pancreas or Kidney-Pancreas	3	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	Nation
Pancreas or Kidney-Pancreas	4	Pancreas or kidney-pancreas candidates	250NM
Kidney	6	Medically urgent; any donor blood type	250NM
Kidney	7	0-ABDR mismatch; CPRA equal to 99%; blood type identical or permissible; any donor blood type	250NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Kidney	8	CPRA equal to 99%; blood type identical or permissible; any donor blood type	250NM
Kidney	9	0-ABDR mismatch; CPRA equal to 98%; blood type identical or permissible; any donor blood type	250NM
Kidney	10	CPRA equal to 98%; blood type identical or permissible; any donor blood type	250NM
Kidney	11	0-ABDR mismatch; blood type identical; any donor blood type	250NM
Kidney	12	0-ABDR mismatch; CPRA greater than or equal to 80%; blood type identical; any donor blood type	Nation
Liver	13	MELD or PELD of at least 33; O donor blood type; O or B candidate blood type	150NM
Liver	14	MELD or PELD of at least 33; non-O donor blood type; any candidate blood type	150NM
Liver	15	MELD or PELD of at least 33; O donor blood type; O or B candidate blood type	250NM
Liver	16	MELD or PELD of at least 33; non-O donor blood type; any candidate blood type	250NM
Liver	17	MELD or PELD of at least 33; O donor blood type; O or B candidate blood type	500NM
Liver	18	MELD or PELD of at least 33; non-O donor blood type; any candidate blood type	500NM
Liver	19	MELD or PELD of at least 30; O donor blood type; O or B candidate blood type	150NM
Liver	20	MELD or PELD of at least 29; O donor blood type; O candidate blood type	150NM
Liver	21	MELD or PELD of at least 29; non-O donor blood type; any candidate blood type	150NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	22	MELD or PELD of at least 30; O donor blood type; O or B candidate blood type	250NM
Liver	23	MELD or PELD of at least 29; O donor blood type; O candidate blood type	250NM
Liver	24	MELD or PELD of at least 29; non-O donor blood type; any candidate blood type	250NM
Liver	25	MELD or PELD of at least 30; O donor blood type; O or B candidate blood type	500NM
Liver	26	MELD or PELD of at least 29; O donor blood type; O candidate blood type	500NM
Liver	27	MELD or PELD of at least 29; non-O donor blood type; any candidate blood type	500NM
Kidney	13	0-ABDR mismatch; CPRA greater than or equal to 21% but no greater than 79%; less than 18 at time of match; blood type identical; any donor blood type	Nation
Kidney	14	0-ABDR mismatch; CPRA greater than or equal to 0% but less than or equal to 20%; less than 18 at time of match; blood type identical; any donor blood type	Nation

5.10.H: Allocation of organs from DCD multi-organ donors at least 18 years old with KDPI less than or equal to 34%

Organs from DCD multi-organ donors at least 18 years old with KDPI less than or equal to 34% are allocated to candidates according to Table 5-9.

Table 5-9 incorporates orders of priority from the following policy tables:

1. Liver Classifications are from *OPTN Policy Table 9-14: Allocation of Livers and Liver-Intestines from DCD Donors or Donors at Least 70 Years Old*
2. Heart Classifications are from *OPTN Policy Table 6-7: Allocation of Hearts from Deceased Donors At Least 18 Years Old*
3. Lung composite allocation score ranges are based on *OPTN Policy 10.1: Lung Composite Allocation Score*
4. Kidney Classifications are from *OPTN Policy Table 8-7: Allocation of Kidneys from Deceased Donors with KDPI Less Than or Equal To 20%* and *OPTN Policy Table 8-8: Allocation of Kidneys from Deceased Donors with KDPI Scores Greater Than 20% but Less Than 35%*
5. Intestine Classifications are from *OPTN Policy Table 7-1: Allocation of Intestines*
6. Pancreas and Kidney-Pancreas Classifications in this table are from *OPTN Policy Table 11-5: Allocation of Kidneys and Pancreas from Deceased Donors 50 Years Old and Less with a BMI Less Than or Equal To 30 kg/m2* and *OPTN Policy Table 11-6: Allocation of Kidneys and Pancreas from Deceased Donors More Than 50 Years Old or with a BMI Greater Than 30 kg/m2*

Table 5-9: Allocation of organs from DCD multi-organ donors at least 18 years old with KDPI less than or equal to 34%

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	1	Status 1A; any donor blood type; any candidate blood type	500NM
Heart	1	Adult Status 1 or Pediatric Status 1A; primary blood type match with the donor	500NM
Heart	2	Adult Status 1 or Pediatric Status 1A; secondary blood type match with the donor	500NM
Liver	2	Status 1B; any donor blood type; any candidate blood type	500NM
Lung	Lung CAS greater than or equal to 41 for O blood type donors; Lung CAS greater than or equal to 37 for non-O blood type donors		
Heart	3	Adult Status 2; primary blood type match with the donor	500NM
Heart	4	Adult Status 2; secondary blood type match with the donor	500NM
Lung	Lung CAS greater than or equal to 35 for O blood type donors; Lung CAS greater than or equal to 31 for non-O blood type donors		
Kidney	1	0-ABDR mismatch; CPRA equal to 100%; blood type identical or	250NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
		permissible; any donor blood type	
Kidney	2	CPRA equal to 100%; blood type identical or permissible; any donor blood type	250NM
Kidney	3	0-ABDR mismatch; CPRA equal to 100%; blood type identical or permissible; any donor blood type	Nation
Kidney	4	CPRA equal to 100%; blood type identical or permissible; any donor blood type	Nation
Kidney	5	Prior living donor; blood type identical or permissible	250NM
Liver	3	MELD or PELD of at least 30; O donor blood type; O or B candidate blood type	150NM
Liver	4	MELD or PELD of at least 15; O donor blood type; O candidate blood type	150NM
Liver	5	MELD or PELD of at least 15; non-O donor blood type; any candidate blood type	150NM
Intestine	1	Status 1; blood type identical to the donor	500NM
Intestine	2	Status 1; blood type compatible with the donor	500NM
Intestine	3	Status 1; blood type identical to the donor	Nation
Intestine	4	Status 1; blood type compatible with the donor	Nation
Lung	Lung CAS greater than or equal to 34 for O blood type donors; Lung CAS greater than or equal to 30 for non-O blood type donors		
Pancreas or Kidney-Pancreas	1	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	250NM
Pancreas or Kidney-Pancreas	2	Either pancreas or kidney-pancreas candidates; CPRA greater than or equal to 80%	250NM
Heart	5	Adult Status 3 or Pediatric Status 1B; primary blood type match with the donor	250NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Heart	6	Adult Status 3 or Pediatric Status 1B; secondary blood type match with the donor	250NM
Pancreas or Kidney-Pancreas	3	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	Nation
Pancreas or Kidney-Pancreas	4	Pancreas or kidney-pancreas candidates	250NM
Kidney	6	Registered prior to 18 years old; blood type identical or permissible; any donor blood type	250NM
Kidney	7	Medically urgent; any donor blood type	250NM
Liver	6	MELD or PELD of at least 30; O donor blood type; O or B candidate blood type	250NM
Liver	7	MELD or PELD of at least 15; O donor blood type; O candidate blood type	250NM
Liver	8	MELD or PELD of at least 15; non-O donor blood type; any candidate blood type	250NM
Liver	9	MELD or PELD of at least 30; O donor blood type; O or B candidate blood type	500NM
Liver	10	MELD or PELD of at least 15; O donor blood type; O candidate blood type	500NM
Liver	11	MELD or PELD of at least 15; non-O donor blood type; any candidate blood type	500NM
Liver	12	Status 1A; any donor blood type; any candidate blood type	Nation
Liver	13	Status 1B; any donor blood type; any candidate blood type	Nation

5.10.I: Allocation of organs from DCD multi-organ donors at least 18 years old with KDPI greater than or equal to 35% but less than or equal to 85%

Organs from DCD multi-organ donors at least 18 years old with KDPI greater than or equal to 35% but less than or equal to 85% are allocated to candidates according to Table 5-10.

Table 5-10 incorporates orders of priority from the following policy tables:

1. Liver Classifications are from *OPTN Policy Table 9-14: Allocation of Livers and Liver-Intestines from DCD Donors or Donors at Least 70 Years Old*
2. Heart Classifications are from *OPTN Policy Table 6-7: Allocation of Hearts from Deceased Donors At Least 18 Years Old*
3. Lung composite allocation score ranges are based on *OPTN Policy 10.1: Lung Composite Allocation Score*
4. Kidney Classifications are from *OPTN Policy Table 8-7: Allocation of Kidneys from Deceased Donors with KDPI Less Than or Equal To 20%* and *OPTN Policy Table 8-8: Allocation of Kidneys from Deceased Donors with KDPI Scores Greater Than 20% but Less Than 35%*
5. Intestine Classifications are from *OPTN Policy Table 7-1: Allocation of Intestines*
6. Pancreas and Kidney-Pancreas Classifications in this table are from *OPTN Policy Table 11-5: Allocation of Kidneys and Pancreas from Deceased Donors 50 Years Old and Less with a BMI Less Than or Equal To 30 kg/m2* and *OPTN Policy Table 11-6: Allocation of Kidneys and Pancreas from Deceased Donors More Than 50 Years Old or with a BMI Greater Than 30 kg/m2*

Table 5-10: Allocation of organs from DCD multi-organ donors at least 18 years old with KDPI greater than or equal to 35% but less than or equal to 85%

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	1	Status 1A; any donor blood type; any candidate blood type	500NM
Heart	1	Adult Status 1 or Pediatric Status 1A; primary blood type match with the donor	500NM
Heart	2	Adult Status 1 or Pediatric Status 1A; secondary blood type match with the donor	500NM
Liver	2	Status 1B; any donor blood type; any candidate blood type	500NM
Lung	Lung CAS greater than or equal to 41 for O blood type donors; Lung CAS greater than or equal to 37 for non-O blood type donors		
Heart	3	Adult Status 2; primary blood type match with the donor	500NM
Heart	4	Adult Status 2; secondary blood type match with the donor	500NM
Lung	Lung CAS greater than or equal to 35 for O blood type donors; Lung CAS greater than or equal to 31 for non-O blood type donors		
Kidney	1	0-ABDR mismatch; CPRA equal to 100%; blood type identical or	250NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
		permissible; any donor blood type	
Kidney	2	CPRA equal to 100%; blood type identical or permissible; any donor blood type	250NM
Kidney	3	0-ABDR mismatch; CPRA equal to 100%; blood type identical or permissible; any donor blood type	Nation
Kidney	4	CPRA equal to 100%; blood type identical or permissible; any donor blood type	Nation
Kidney	5	Prior living donor; blood type identical or permissible	250NM
Liver	3	MELD or PELD of at least 30; O donor blood type; O or B candidate blood type	150NM
Liver	4	MELD or PELD of at least 15; O donor blood type; O candidate blood type	150NM
Liver	5	MELD or PELD of at least 15; non-O donor blood type; any candidate blood type	150NM
Intestine	1	Status 1; blood type identical to the donor	500NM
Intestine	2	Status 1; blood type compatible with the donor	500NM
Intestine	3	Status 1; blood type identical to the donor	Nation
Intestine	4	Status 1; blood type compatible with the donor	Nation
Lung	Lung CAS greater than or equal to 34 for O blood type donors; Lung CAS greater than or equal to 30 for non-O blood type donors		
Pancreas or Kidney-Pancreas	1	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	250NM
Pancreas or Kidney-Pancreas	2	Either pancreas or kidney-pancreas candidates; CPRA greater than or equal to 80%	250NM
Heart	5	Adult Status 3 or Pediatric Status 1B; primary blood type match with the donor	250NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Heart	6	Adult Status 3 or Pediatric Status 1B; secondary blood type match with the donor	250NM
Pancreas or Kidney-Pancreas	3	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	Nation
Pancreas or Kidney-Pancreas	4	Pancreas or kidney-pancreas candidates	250NM
Kidney	6	Medically urgent; any donor blood type	250NM
Kidney	7	0-ABDR mismatch; CPRA equal to 99%; blood type identical or permissible; any donor blood type	250NM
Kidney	8	CPRA equal to 99%; blood type identical or permissible; any donor blood type	250NM
Kidney	9	0-ABDR mismatch; CPRA equal to 98%; blood type identical or permissible; any donor blood type	250NM
Kidney	10	CPRA equal to 98%; blood type identical or permissible; any donor blood type	250NM
Kidney	11	0-ABDR mismatch; blood type identical; any donor blood type	250NM
Kidney	12	0-ABDR mismatch; CPRA greater than or equal to 80%; blood type identical; any donor blood type	Nation
Kidney	13	0-ABDR mismatch; CPRA greater than or equal to 21% but no greater than 79%; less than 18 at time of match; blood type identical; any donor blood type	Nation
Kidney	14	0-ABDR mismatch; CPRA greater than or equal to 0% but less than or equal to 20%; less than 18 at time of match; blood type identical; any donor blood type	Nation

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	6	MELD or PELD of at least 30; O donor blood type; O or B candidate blood type	250NM
Liver	7	MELD or PELD of at least 15; O donor blood type; O candidate blood type	250NM
Liver	8	MELD or PELD of at least 15; non-O donor blood type; any candidate blood type	250NM
Liver	9	MELD or PELD of at least 30; O donor blood type; O or B candidate blood type	500NM
Liver	10	MELD or PELD of at least 15; O donor blood type; O candidate blood type	500NM
Liver	11	MELD or PELD of at least 15; non-O donor blood type; any candidate blood type	500NM
Liver	12	Status 1A; any donor blood type; any candidate blood type	Nation
Liver	13	Status 1B; any donor blood type; any candidate blood type	Nation

5.10.J: Allocation of organs from non-DCD donors 11 to 17 years old with KDPI less than or equal to 34%

Organs from non-DCD donors 11 to 17 years old with KDPI less than or equal to 34% are allocated according to Table 5-11.

Table 5-11 incorporates orders of priority from the following policy tables:

1. Liver Classifications are from *OPTN Policy Table 9-12: Allocation of Livers from Non-DCD Deceased Donors 11 to 17 Years Old*
2. Heart Classifications are from *OPTN Policy Table 6-8: Allocation of Hearts from Donors Less Than 18 Years Old*
3. Lung composite allocation score ranges are based on *OPTN Policy 10.1: Lung Composite Allocation Score*
4. Kidney Classifications are from *OPTN Policy Table 8-7: Allocation of Kidneys from Deceased Donors with KDPI Less Than or Equal To 20%* and *OPTN Policy Table 8-8: Allocation of Kidneys from Deceased Donors with KDPI Scores Greater Than 20% but Less Than 35%*
5. Intestine Classifications are from *OPTN Policy Table 7-1: Allocation of Intestines*
6. Pancreas and Kidney-Pancreas Classifications in this table are from *OPTN Policy Table 11-5: Allocation of Kidneys and Pancreas from Deceased Donors 50 Years Old and Less with a BMI Less Than or Equal To 30 kg/m2* and *OPTN Policy Table 11-6: Allocation of Kidneys and Pancreas from Deceased Donors More Than 50 Years Old or with a BMI Greater Than 30 kg/m2*

Table 5-11: Allocation of organs from non-DCD donors 11 to 17 years old with KDPI less than or equal to 34%

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	1	Pediatric Status 1A; any donor blood type; any candidate blood type	500NM
Liver	2	Adult Status 1A; any donor blood type; any candidate blood type	500NM
Heart	1	Pediatric status 1A and primary blood type match with the donor	500NM
Heart	2	Pediatric status 1A and secondary blood type match with the donor	500NM
Heart	3	Adult status 1 and primary blood type match with the donor	250NM
Heart	4	Adult status 1 and secondary blood type match with the donor	250NM
Liver	3	Pediatric Status 1B; any donor blood type; any candidate blood type	500NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	4	Pediatric Status 1A; any donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	5	Adult Status 1A; any donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	6	Pediatric Status 1B; any donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Lung	Lung CAS greater than or equal to 41 for O blood type donors; Lung CAS greater than or equal to 37 for non-O blood type donors		
Heart	5	Adult status 2 and primary blood type match with the donor	250NM
Heart	6	Adult status 2 and secondary blood type match with the donor	250NM
Heart	7	Pediatric status 1B and primary blood type match with the donor	500NM
Heart	8	Pediatric status 1B and secondary blood type match with the donor	500NM
Lung	Lung CAS greater than or equal to 35 for O blood type donors; Lung CAS greater than or equal to 31 for non-O blood type donors		
Kidney	1	0-ABDR mismatch; CPRA equal to 100%; blood type identical or permissible; any donor blood type	250NM
Kidney	2	CPRA equal to 100%; blood type identical or permissible; any donor blood type	250NM
Kidney	3	0-ABDR mismatch; CPRA equal to 100%; blood type identical or permissible; any donor blood type	Nation
Kidney	4	CPRA equal to 100%; blood type identical or permissible; any donor blood type	Nation
Kidney	5	Prior living donor; blood type identical or permissible	250NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	7	PELD of at least 37; O donor blood type; O or B candidate blood type	500NM
Liver	8	PELD of at least 37; non-O donor blood type; any candidate blood type	500NM
Liver	9	PELD of at least 37; O donor blood type; O or B candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	10	PELD of at least 37; O donor blood type; O or B candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	11	PELD of at least 30; O donor blood type; O or B candidate blood type	500NM
Liver	12	Any PELD; O donor blood type; O candidate blood type	500NM
Liver	13	Any PELD; non-O donor blood type; any candidate blood type	500NM
Liver	14	MELD of at least 37 and candidate is less than 18 years old at registration; O donor blood type; O or B candidate blood type	500NM
Liver	15	MELD of at least 37 and candidate is less than 18 years old at registration; non-O donor blood type; any candidate blood type	500NM
Liver	16	MELD of at least 37 and candidate is less than 18 years old at registration; O donor blood type; O or B candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	17	MELD of at least 37 and candidate is less than 18 years old at registration; non-O donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Lung	Lung CAS greater than or equal to 34 for O blood type donors; Lung CAS greater than or equal to 30 for non-O blood type donors		

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	18	MELD of at least 30 and candidate is less than 18 years old at registration; O donor blood type; O or B candidate blood type	500NM
Liver	19	Any MELD and candidate is less than 18 years old at registration; O donor blood type; O candidate blood type	500NM
Liver	20	Any MELD and candidate is less than 18 years old at registration; non-O donor blood type; any candidate blood type	500NM
Liver	21	Pediatric Status 1A; any donor blood type; any candidate blood type	Nation
Liver	22	Adult Status 1A; any donor blood type; any candidate blood type	Nation
Liver	23	Pediatric Status 1B; any donor blood type; any candidate blood type	Nation
Intestine	1	Status 1; blood type identical to the donor	500NM
Intestine	2	Status 1; blood type compatible with the donor	500NM
Intestine	3	Status 1; blood type identical to the donor	Nation
Intestine	4	Status 1; blood type compatible with the donor	Nation
Pancreas or Kidney-Pancreas	1	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	250NM
Pancreas or Kidney-Pancreas	2	Either pancreas or kidney-pancreas candidates; CPRA greater than or equal to 80%	250NM
Pancreas or Kidney-Pancreas	3	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	Nation
Kidney	6	Registered prior to 18 years old; blood type identical or	250NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
		permissible; any donor blood type	
Pancreas or Kidney-Pancreas	4	Pancreas or kidney-pancreas candidates	250NM
Kidney	7	Medically urgent; any donor blood type	250NM

5.10.K: Allocation of organs from non-DCD multi-organ donors less than 11 years old with liver and intestines available and KDPI less than or equal to 34%

Organs from non-DCD multi-organ donors less than 11 years old with liver and intestines available and KDPI less than or equal to 34% are allocated according to Table 5-12.

Table 5-12 incorporates orders of priority from the following policy tables:

1. Liver Classifications are from *OPTN Policy Table 9-16: Allocation of Liver-Intestines from Non-DCD Donors Less than 11 Years Old*
2. Heart Classifications are from *OPTN Policy Table 6-8: Allocation of Hearts from Donors Less Than 18 Years Old*
3. Lung composite allocation score ranges are based on *OPTN Policy 10.1: Lung Composite Allocation Score*
4. Kidney Classifications are from *OPTN Policy Table 8-7: Allocation of Kidneys from Deceased Donors with KDPI Less Than or Equal To 20%* and *OPTN Policy Table 8-8: Allocation of Kidneys from Deceased Donors with KDPI Scores Greater Than 20% but Less Than 35%*
5. Intestine Classifications are from *OPTN Policy Table 7-1: Allocation of Intestines*
6. Pancreas and Kidney-Pancreas Classifications in this table are from *OPTN Policy Table 11-5: Allocation of Kidneys and Pancreas from Deceased Donors 50 Years Old and Less with a BMI Less Than or Equal To 30 kg/m2* and *OPTN Policy Table 11-6: Allocation of Kidneys and Pancreas from Deceased Donors More Than 50 Years Old or with a BMI Greater Than 30 kg/m2*

Table 5-12: Allocation of organs from non-DCD multi-organ donors less than 11 years old with liver and intestines available and KDPI less than or equal to 34%

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	1	Pediatric Status 1A; any donor blood type; any candidate blood type	500NM
Liver	2	Pediatric Status 1A and candidate is less than 12 years old; any donor blood type; any candidate blood type	Nation
Liver	3	Pediatric Status 1A, candidate is at least 12 years old, and candidate is also registered for an intestine; any donor blood type; any candidate blood type	Nation
Liver	4	Adult Status 1A; any donor blood type; any candidate blood type	500NM
Heart	1	Pediatric status 1A and primary blood type match with the donor	500NM
Heart	2	Pediatric status 1A and secondary blood type match with the donor	500NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Heart	3	Adult status 1 and primary blood type match with the donor	250NM
Heart	4	Adult status 1 and secondary blood type match with the donor	250NM
Liver	5	Pediatric Status 1B; any donor blood type; any candidate blood type	500NM
Liver	6	Pediatric Status 1A and candidate is at least 12 years old; any donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	7	Adult Status 1A	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	8	Pediatric Status 1B	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Lung	Lung CAS greater than or equal to 41 for O blood type donors; Lung CAS greater than or equal to 37 for non-O blood type donors		
Heart	5	Adult status 2 and primary blood type match with the donor	250NM
Heart	6	Adult status 2 and secondary blood type match with the donor	250NM
Heart	7	Pediatric status 1B and primary blood type match with the donor	500NM
Heart	8	Pediatric status 1B and secondary blood type match with the donor	500NM
Lung	Lung CAS greater than or equal to 35 for O blood type donors; Lung CAS greater than or equal to 31 for non-O blood type donors		
Kidney	1	0-ABDR mismatch; CPRA equal to 100%; blood type identical or permissible; any donor blood type	250NM
Kidney	2	CPRA equal to 100%; blood type identical or permissible; any donor blood type	250NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Kidney	3	0-ABDR mismatch; CPRA equal to 100%; blood type identical or permissible; any donor blood type	Nation
Kidney	4	CPRA equal to 100%; blood type identical or permissible; any donor blood type	Nation
Kidney	5	Prior living donor; blood type identical or permissible	250NM
Intestine	1	Status 1; blood type identical to the donor	500NM
Intestine	2	Status 1; blood type compatible with the donor	500NM
Intestine	3	Status 1; blood type identical to the donor	Nation
Intestine	4	Status 1; blood type compatible with the donor	Nation
Liver	9	PELD of at least 37; O donor blood type; O or B candidate blood type	500NM
Liver	10	PELD of at least 37; non-O donor blood type; any candidate blood type	500NM
Liver	11	PELD of at least 37; O donor blood type; O or B candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	12	PELD of at least 37; non-O donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	13	PELD of at least 30; O donor blood type; O or B candidate blood type	500NM
Liver	14	PELD of at least 20; O donor blood type; O candidate blood type	500NM
Liver	15	PELD of at least 20; non-O donor blood type; any candidate blood type	500NM
Liver	16	Pediatric Status 1B; candidate is also registered for an intestine;	Nation

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
		any donor blood type; any candidate blood type	
Liver	17	PELD of at least 30; candidate is also registered for an intestine; O donor blood type; O or B candidate blood type	Nation
Liver	18	PELD of at least 20; candidate also registered for an intestine; O donor blood type; O candidate blood type	Nation
Liver	19	PELD of at least 20; candidate also registered for an intestine; non-O donor blood type; any candidate blood type	Nation
Liver	20	Any PELD; O donor blood type; O candidate blood type	500NM
Liver	21	Any PELD; non-O donor blood type; any candidate blood type	500NM
Liver	22	MELD of at least 37; candidate is less than 18 years old at registration; O donor blood type; O or B candidate blood type	500NM
Liver	23	MELD of at least 37; candidate is less than 18 years old at registration; non-O donor blood type; any candidate blood type	500NM
Liver	24	MELD of at least 37; candidate is less than 18 years old at registration; O donor blood type; O or B candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	25	MELD of at least 37; candidate is less than 18 years old at registration; non-O donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Lung	Lung CAS greater than or equal to 34 for O blood type donors; Lung CAS greater than or equal to 30 for non-O blood type donors		
Liver	26	MELD of at least 30; less than 18 years old at registration; O donor blood type; O or B candidate blood type	500NM
Liver	27	Any MELD; less than 18 years old at registration; O donor blood type; O candidate blood type	500NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	28	Any MELD; less than 18 years old at registration; non-O donor blood type; any candidate blood type	500NM
Kidney	6	Registered prior to 18 years old; blood type identical or permissible; any donor blood type	250NM
Pancreas or Kidney-Pancreas	1	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	250NM
Pancreas or Kidney-Pancreas	2	Either pancreas or kidney-pancreas candidates; CPRA greater than or equal to 80%	250NM
Pancreas or Kidney-Pancreas	3	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	Nation
Pancreas or Kidney-Pancreas	4	Pancreas or kidney-pancreas candidates	250NM
Kidney	7	Medically urgent; any donor blood type	250NM

5.10.L: Allocation of organs from non-DCD multi-organ donors less than 11 years old with liver and intestines available and KDPI greater than or equal to 35% but less than or equal to 85%

Organs from non-DCD multi-organ donors less than 11 years old with liver and intestines available and KDPI greater than or equal to 35% but less than or equal to 85% are allocated according to Table 5-13.

Table 5-13 incorporates orders of priority from the following policy tables:

1. Liver Classifications are from *OPTN Policy Table 9-16: Allocation of Liver-Intestines from Non-DCD Donors Less than 11 Years Old*
2. Heart Classifications are from *OPTN Policy Table 6-8: Allocation of Hearts from Donors Less Than 18 Years Old*
3. Lung composite allocation score ranges are based on *OPTN Policy 10.1: Lung Composite Allocation Score*
4. Kidney Classifications are from *OPTN Policy Table 8-9: Allocation of Kidneys from Deceased Donors with KDPI Greater Than or Equal To 35% and Less Than or Equal To 85%*
5. Intestine Classifications are from *OPTN Policy Table 7-1: Allocation of Intestines*
6. Pancreas and Kidney-Pancreas Classifications in this table are from *OPTN Policy Table 11-5: Allocation of Kidneys and Pancreas from Deceased Donors 50 Years Old and Less with a BMI Less Than or Equal To 30 kg/m2* and *OPTN Policy Table 11-6: Allocation of Kidneys and Pancreas from Deceased Donors More Than 50 Years Old or with a BMI Greater Than 30 kg/m2*

Table 5-13: Allocation of organs from non-DCD multi-organ donors less than 11 years old with liver and intestines available and KDPI greater than or equal to 35% but less than or equal to 85%

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	1	Pediatric Status 1A; any donor blood type; any candidate blood type	500NM
Liver	2	Pediatric Status 1A and candidate is less than 12 years old; any donor blood type; any candidate blood type	Nation
Liver	3	Pediatric Status 1A, candidate is at least 12 years old, and candidate is also registered for an intestine; any donor blood type; any candidate blood type	Nation
Liver	4	Adult Status 1A; any donor blood type; any candidate blood type	500NM
Heart	1	Pediatric status 1A and primary blood type match with the donor	500NM
Heart	2	Pediatric status 1A and secondary blood type match with the donor	500NM
Heart	3	Adult status 1 and primary blood type match with the donor	250NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Heart	4	Adult status 1 and secondary blood type match with the donor	250NM
Liver	5	Pediatric Status 1B; any donor blood type; any candidate blood type	500NM
Liver	6	Pediatric Status 1A and candidate is at least 12 years old; any donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	7	Adult Status 1A	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	8	Pediatric Status 1B	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Lung	Lung CAS greater than or equal to 41 for O blood type donors; Lung CAS greater than or equal to 37 for non-O blood type donors		
Heart	5	Adult status 2 and primary blood type match with the donor	250NM
Heart	6	Adult status 2 and secondary blood type match with the donor	250NM
Heart	7	Pediatric status 1B and primary blood type match with the donor	500NM
Heart	8	Pediatric status 1B and secondary blood type match with the donor	500NM
Lung	Lung CAS greater than or equal to 35 for O blood type donors; Lung CAS greater than or equal to 31 for non-O blood type donors		
Kidney	1	0-ABDR mismatch; CPRA equal to 100%; blood type identical or permissible; any donor blood type	250NM
Kidney	2	CPRA equal to 100%; blood type identical or permissible; any donor blood type	250NM
Kidney	3	0-ABDR mismatch; CPRA equal to 100%; blood type identical or	Nation

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
		permissible; any donor blood type	
Kidney	4	CPRA equal to 100%; blood type identical or permissible; any donor blood type	Nation
Kidney	5	Prior living donor; blood type identical or permissible	250NM
Intestine	1	Status 1; blood type identical to the donor	500NM
Intestine	2	Status 1; blood type compatible with the donor	500NM
Intestine	3	Status 1; blood type identical to the donor	Nation
Intestine	4	Status 1; blood type compatible with the donor	Nation
Liver	9	PELD of at least 37; O donor blood type; O or B candidate blood type	500NM
Liver	10	PELD of at least 37; non-O donor blood type; any candidate blood type	500NM
Liver	11	PELD of at least 37; O donor blood type; O or B candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	12	PELD of at least 37; non-O donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	13	PELD of at least 30; O donor blood type; O or B candidate blood type	500NM
Liver	14	PELD of at least 20; O donor blood type; O candidate blood type	500NM
Liver	15	PELD of at least 20; non-O donor blood type; any candidate blood type	500NM
Liver	16	Pediatric Status 1B; candidate is also registered for an intestine; any donor blood type; any candidate blood type	Nation

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Liver	17	PELD of at least 30; candidate is also registered for an intestine; O donor blood type; O or B candidate blood type	Nation
Liver	18	PELD of at least 20; candidate also registered for an intestine; O donor blood type; O candidate blood type	Nation
Liver	19	PELD of at least 20; candidate also registered for an intestine; non-O donor blood type; any candidate blood type	Nation
Liver	20	Any PELD; O donor blood type; O candidate blood type	500NM
Liver	21	Any PELD; non-O donor blood type; any candidate blood type	500NM
Liver	22	MELD of at least 37; candidate is less than 18 years old at registration; O donor blood type; O or B candidate blood type	500NM
Liver	23	MELD of at least 37; candidate is less than 18 years old at registration; non-O donor blood type; any candidate blood type	500NM
Liver	24	MELD of at least 37; candidate is less than 18 years old at registration; O donor blood type; O or B candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Liver	25	MELD of at least 37; candidate is less than 18 years old at registration; non-O donor blood type; any candidate blood type	2,400NM and candidate is registered in Hawaii or 1,100NM and candidate is registered in Puerto Rico
Lung	Lung CAS greater than or equal to 34 for O blood type donors; Lung CAS greater than or equal to 30 for non-O blood type donors		
Liver	26	MELD of at least 30; less than 18 years old at registration; O donor blood type; O or B candidate blood type	500NM
Liver	27	Any MELD; less than 18 years old at registration; O donor blood type; O candidate blood type	500NM
Liver	28	Any MELD; less than 18 years old at registration; non-O donor	500NM

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
		blood type; any candidate blood type	
Pancreas or Kidney-Pancreas	1	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	250NM
Pancreas or Kidney-Pancreas	2	Either pancreas or kidney-pancreas candidates; CPRA greater than or equal to 80%	250NM
Pancreas or Kidney-Pancreas	3	Either pancreas or kidney-pancreas candidates; 0-ABDR mismatch; CPRA greater than or equal to 80%	Nation
Pancreas or Kidney-Pancreas	4	Pancreas or kidney-pancreas candidates	250NM
Kidney	6	Medically urgent; any donor blood type	250NM
Kidney	7	0-ABDR mismatch; CPRA equal to 99%; blood type identical or permissible; any donor blood type	250NM
Kidney	8	CPRA equal to 99%; blood type identical or permissible; any donor blood type	250NM
Kidney	9	0-ABDR mismatch; CPRA equal to 98%; blood type identical or permissible; any donor blood type	250NM
Kidney	10	CPRA equal to 98%; blood type identical or permissible; any donor blood type	250NM
Kidney	11	0-ABDR mismatch; blood type identical; any donor blood type	250NM
Kidney	12	0-ABDR mismatch; CPRA greater than or equal to 80%; blood type identical; any donor blood type	Nation
Kidney	13	0-ABDR mismatch; CPRA greater than or equal to 21% but no greater than 79%; less than 18 at time of match; blood type identical; any donor blood type	Nation

Organ	Classification	Description	And registered at a transplant hospital that is at or within this distance from the donor hospital
Kidney	14	0-ABDR mismatch; CPRA greater than or equal to 0% but less than or equal to 20%; less than 18 at time of match; blood type identical; any donor blood type	Nation

~~**6.6.F Allocation of Heart-Lungs**~~

~~**6.6.F.i Allocation of Heart-Lungs from Deceased Donors at Least 18 Years Old**~~

~~If a host OPO is offering a heart and lung from the same deceased donor, then the host OPO must offer the heart and lung in the following order:~~

1. ~~To all heart and heart-lung PTRs in allocation classifications 1 through 4 according to *OPTN Policy 6.6.D: Allocation of Hearts from Donors at Least 18 Years Old*~~
2. ~~To all lung and heart-lung PTRs according to *OPTN Policy 10.1 Lung Composite Allocation Score* until offers have been made to all heart-lung PTRs with a lung composite allocation score of 25 or higher~~
3. ~~To heart and heart-lung PTRs in classifications 5 or later according to *OPTN Policy 6.6.D: Allocation of Hearts from Donors at Least 18 Years Old*.~~

~~The host OPO must follow the order on each match run, including heart-lung, heart, and lung candidates.~~

8.6.A: Choice of Right versus Left Donor Kidney

If both kidneys from a deceased donor are able to be transplanted, the transplant hospital that received the offer for the ~~candidate~~ potential transplant recipient with higher priority, ~~on the waiting list~~ as determined by *Policy 5.10: Allocation of Organs from Deceased Multi-Organ Donors* or individual organ allocation policies, will get to choose first which of the two kidneys it will receive.

~~However, when a kidney is offered to a 0-ABDR mismatched candidate, a candidate with a CPRA greater than or equal to 99% (classifications 1 through 4, 8 or 9 in Tables 8-7 and 8-8; classifications 1 through 4, 7 or 8 in Table 8-9; and classifications 1 through 4, 6 or 7 in Table 8-10) or to a combined kidney and non-renal organ candidate, the host OPO determines whether to offer the left or the right kidney.~~

~~**8.6.C Kidney Allocation in Multi-Organ Combinations**~~

~~If a host OPO procures a kidney along with other organs, the host OPO must first offer the kidney according to one of the following policies before allocating the kidney to kidney alone candidates according to *OPTN Policy 8: Allocation of Kidneys:*~~

- ~~OPTN Policy 5.10.E: Allocation of Heart-Kidneys~~
- ~~OPTN Policy 5.10.F: Allocation of Lung-Kidneys~~
- ~~OPTN Policy 9.9: Liver-Kidney Allocation~~
- ~~OPTN Policy 11.4.A: Kidney-Pancreas Allocation Order~~

9.8.F: Allocation of Livers and Liver-Intestines from Non-DCD Deceased Donors 11-17 Years Old

Livers and liver-intestines from non-DCD deceased donors 11 to 17 years old are allocated to candidates according to *Table 9-12* below.

~~**9.8.J: Allocation of Liver-Intestines from Non-DCD Donors 11-17 Years Old**~~

~~For combined liver-intestine allocation from non-DCD donors 11 to 17 years old, the liver must first be offered as follows:~~

- ~~According to *Policy 9.8.F: Allocation of Livers from Non-DCD Deceased Donors 11 to 17 Years Old*~~
- ~~Sequentially to *each* liver candidate, including all MELD and PELD candidates, through national status 1A and 1B offers~~

~~The liver may then be offered to combined liver-intestine potential recipients sequentially according to the intestine match run.~~

9.9: Liver-Kidney Allocation

Unless otherwise stated, all mentions of MELD in this section reference a candidate's allocation MELD score.

When an OPO is offering a liver, and a kidney is also available from the same deceased donor, then before allocating the kidney to kidney alone candidates, the OPO must offer the kidney to a potential transplant recipient (PTR) who is registered for a liver and a kidney at the same transplant hospital, and who meets one of the following criteria:

a) PTR was less than 18 years old when registered on the liver waiting list
b) PTR is registered at a transplant hospital at or within 150 nautical miles of the donor hospital and has a MELD of 15 or greater and meets eligibility criteria according to *Table 9-17: Medical Eligibility Criteria for Liver-Kidney Allocation*
c) PTR is registered at a transplant hospital at or within 500 nautical miles of the donor hospital and has a MELD of 29 or greater and meets eligibility criteria according to *Table 9-17: Medical Eligibility Criteria for Liver-Kidney Allocation*
d) PTR is registered at a transplant hospital at or within 500 nautical miles of the donor hospital and is adult status 1A and meets eligibility criteria according to *Table 9-17: Medical Eligibility Criteria for Liver-Kidney Allocation*

The OPO may then offer the kidney and liver to any PTRs who meet eligibility in *Table 9-17: Medical Eligibility Criteria for Liver-Kidney Allocation*, or offer the liver and the kidney separately according to policy.

Table 9-17: Medical Eligibility Criteria for Liver-Kidney Allocation

If the candidate's transplant nephrologist confirms a diagnosis of:	Then the transplant program must report to the OPTN and document in the candidate's medical record:
Chronic kidney disease (CKD) with a measured or estimated glomerular filtration rate (GFR) less than or equal to 60 mL/min for greater than 90 consecutive days	At least *one* of the following: • That the candidate has begun regularly administered dialysis as an end-stage renal disease (ESRD) patient in a hospital based, independent non-hospital based, or home setting. • At the time of registration on the kidney waiting list, that the candidate's most recent measured or estimated creatinine clearance (CrCl) or GFR is less than or equal to 30 mL/min. • On a date after registration on the kidney waiting list, that the candidate's measured or estimated CrCl or GFR is less than or equal to 30 mL/min.
Sustained acute kidney injury	At least one of the following, or a combination of both of the following, for the last 6 weeks: • That the candidate has been on dialysis at least once every 7 days. • That the candidate has a measured or estimated CrCl or GFR less than or equal to 25 mL/min at least once every 7 days.

~~If the candidate's transplant nephrologist confirms a diagnosis of:~~	~~Then the transplant program must report to the OPTN and document in the candidate's medical record:~~
	~~If the candidate's eligibility is not confirmed at least once every seven days for the last 6 weeks, the candidate is not eligible to receive a liver and a kidney from the same donor.~~
~~Metabolic disease~~	~~A diagnosis of at least *one* of the following:~~ ~~• Hyperoxaluria~~ ~~• Atypical hemolytic uremic syndrome (HUS) from mutations in factor H or factor I~~ ~~• Familial non-neuropathic systemic amyloidosis~~ ~~• Methylmalonic aciduria~~

9.12.B: Closed Variance for Allocation of Blood Type O Deceased Donor Livers

This is a closed variance that applies only to liver and liver-intestine organs allocated by the OPOs in Hawaii and Puerto Rico to potential transplant recipients registered at transplant programs in Hawaii and Puerto Rico, respectively due to geographic location. This variance supersedes the treatment of blood type O donors according to *OPTN Policy 9.8.C Allocation of Livers by Blood Type* and allocation of livers according to the multi-organ allocation tables in *OPTN Policy 5.10 Allocation of Organs from Deceased Multi-Organ Donors*, and instead the OPO will allocate these blood type O organs to potential transplant recipients with any blood type within the same classification.

11.4.A Kidney-Pancreas Allocation Order

If a host OPO has both a kidney and a pancreas to offer for allocation, then the host OPO:

1. Must comply with *Policy 5.10: Allocation of Organs from Deceased Multi-Organ Donors*. ~~Must offer the kidney and pancreas according to classifications 1–4 in *Table 11-5: Allocation of Kidneys and Pancreas from Deceased Donors 50 Years Old and Less with a BMI less than or equal to 30 kg/m^2* and *Table 11-6: Allocation of Kidneys and Pancreas from Donors more than 50 Years Old or with a BMI greater than 30 kg/m^2*.~~

2. Then, the host OPO may do *either*:
    a. ~~Continue to o~~Offer the kidney and pancreas according to the ~~remaining~~ classifications in *Table 11-5: Allocation of Kidneys and Pancreas from Deceased Donors 50 Years Old and Less with a BMI less than or equal to 30 kgm^2* and *Table-6: Allocation of Kidneys and Pancreas from Donors more than 50 Years Old or with a BMI greater than 30 kgm^2*.
    b. Offer the pancreas to pancreas and islet candidates, but not kidney-pancreas candidates, according to the ~~remaining~~ classifications in *Table 11-5 and Table 11-6* and offer the kidney to kidney candidates according to *Policy 8: Allocation of Kidneys*.

The host OPO may switch between options 2.a and 2.b above at any time after completing step 1 above.

This subsection does not apply if the kidney and pancreas have been released according to *Policy 5.9: Released Organs.*