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We want to thank the reviewers for their encouraging and positive feedback on our work. Please find the answers to the specific questions and comments below.

Reviewer number 502973

Minor concerns: 1. Discussion, 2nd paragraph: Our findings challenge the notion of a defined abstinence period as the only criterion for liver transplant eligibility in patient with liver cirrhosis[18]. I would suggest change "liver cirrhosis" to "alcoholic liver cirrhosis". 2. Discussion, 3rd paragraph: "…intention to remain abstinent form alcohol,…". "form" should change to "from".

Thank you. Both sentences were corrected in the manuscript accordingly.

Reviewer number 2860814

1) 279 patients (85%) of the total population were considered as high risk for recidivism alcohol consumption and underwent the standard chemical dependency requirements. Do we have data on this population regarding survival, transplant rates, survival after liver transplantation and recidivism after liver transplantation.

Thank you for the comment. Unfortunately, we don't have data at the moment of 279 patients who were considered high risk recidivism.

2) 11 patients (47 minus 36) were not approved from the consortium despite they have been considered eligible from social workers and liver transplant committee at the Cleveland Clinic. Which were the criteria for rejection from the consortium?

This has happened in the cases where the Ohio Solid Organ Transplantation Consortium (OSOTC) decided a patient to be high-risk, despite the patient being considered low or medium risk by the CCF review committee. Specifically this has happened due to the severity of the patient's alcohol use history, and lack of insight

regarding the importance of maintaining his sobriety. When we were discussing these patients with our transplant social worker who is a member of the writing group on this paper, she made some comments that we think are appropriate to quote here:

"The more you do the calls [to determine patients' eligibility for medically urgent exception criteria in patients with chemical dependency], the more you learn how a patient's alcohol use history, current status, level of insight or not, where the patient fits between high - (not a candidate) to medium or low (might be a candidate). I think there is value in presenting to professionals who do the same job (other Tx SW'ers) but have no bias since they don't know the patient. It helps to make sure we're evaluating consistently between the programs and following the written guidelines. A few years ago, we added the insight piece to our criteria. When the DSM changed from the 4th version to the 5th version, we updated our policy at the OSOTC accordingly. So, the exception criteria has appropriately evolved but remained the same by using training and clinical practice to make these extremely important decisions."

3) 17/36 patients dropped off the transplant list. Which were the reasons in details (number, percentages) for drop off. In particular for infections, more details regarding type of microorganisms, type of infection, community or hospital acquired is needed.

The most common cause of drop-off in the two groups was infection (68%), including spontaneous bacterial infection, health-care associated pneumonia and urinary tract infection. Please see page 10 of the manuscript.

4) Did authors investigate for any factors that could predict recidivism after liver transplantation?

Thank you for this comment. Unfortunately the answer is no. Due to small number of patients, we won't have the required power to address this question.

5) Which were the recidivism rates in the control group?

Thank you for the comment. We have used the reported rates of recidivism in US population as an external control.

6) Are there any information regarding outcome of 4 patients who restart drinking after liver transplantation? Were there any strategies to achieve alcohol cessation again?

The four patients who restart drinking after liver transplant were followed. They were all enrolled in intense chemical dependency treatment. Unfortunately, all relapsed shortly following completion of chemical dependency program. One died due to severe alcoholic hepatitis. The other three are still alive (one with cirrhosis and portal hypertension, one with recurrent liver rejection due to poor compliance with anti-rejection medicine, and one with recurrent admission to hospital with alcohol withdraw).

7) Are there any information regarding compliance with immunosuppressive medication regimens?

Compliance with immunosuppressant medications was poor (25%) among the four patients restart alcohol following liver transplantation. In contrast, patients who remained sober after liver transplant were complaint with immunosuppressant medications (98%).

8) What were the percentage for patients in both groups with a significant recovery of liver function so that they no longer require transplant.

Thank you for the comment. We observed recovery in liver functions where liver transplant was no longer indicated in two patients of our cohort. This information is not available in the control group that was extracted from UNOS database.