

# Esophagus Cancer Radiation Therapy Physician Worksheet (As of 26 January 2017)

This worksheet is to be used for curative or palliative treatment of esophagus cancer. If the treatment is for metastases from esophagus cancer, please use the appropriate metastatic worksheet.

For NON-URGENT requests, please complete this document for authorization along with any relevant clinical documentation requested within this document (i.e. radiation therapy consultation, comparison plan, etc.) before submitting the case by web, phone, or fax. Failure to provide all relevant information may delay the determination. Phone and fax numbers can be found on [evicore.com](http://evicore.com) under the Guidelines and Fax Forms section. You may also log into the provider portal located on the site to submit an authorization request. **URGENT (same day) requests must be submitted by phone.**

<b>First Name:</b>	<b>Middle Initial:</b>	<b>Last Name:</b>
<b>DOB (mm/dd/yyyy):</b>		<b>Member ID:</b>
<b>What is the radiation therapy treatment start date (mm/dd/yyyy)?</b>		____ / ____ / ____
1.	Does the patient have distant metastases (stage M1) (i.e. to brain, lung, liver, bone)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	What is the location of the tumor? <input type="checkbox"/> Cervical <input type="checkbox"/> Upper thoracic <input type="checkbox"/> Mid thoracic <input type="checkbox"/> Lower thoracic/GEJ	
3.	What is the clinical or pathologic T-stage? <input type="checkbox"/> T1a <input type="checkbox"/> T2 <input type="checkbox"/> T4a <input type="checkbox"/> T1b <input type="checkbox"/> T3 <input type="checkbox"/> T4b	
4.	What is the clinical or pathologic N-stage? <input type="checkbox"/> N0 <input type="checkbox"/> N1 <input type="checkbox"/> N2 <input type="checkbox"/> N3	
5.	What is the treatment intent? <input type="checkbox"/> Preoperative (neo-adjuvant) <input type="checkbox"/> Definitive (no surgery planned) <input type="checkbox"/> Postoperative (adjuvant) <input type="checkbox"/> Palliative (for relief of symptoms)	

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6.	What is the treatment plan?		
	<input type="checkbox"/> External beam radiation therapy (EBRT) <input type="checkbox"/> Brachytherapy <input type="checkbox"/> Brachytherapy and EBRT		
7.	If EBRT is included in the treatment plan, then answer the following set of questions: a. What is the treatment technique? <i>Select a technique for each applicable phase and fill in the number fractions.</i>		
	Phase 1	Phase 2	
	Phase 3		
	<input type="checkbox"/> 3D conformal	<input type="checkbox"/> 3D conformal	<input type="checkbox"/> 3D conformal
	<input type="checkbox"/> Complex treatment (77307) (DVH not medically necessary)	<input type="checkbox"/> Complex treatment (77307) (DVH not medically necessary)	<input type="checkbox"/> Complex treatment (77307) (DVH not medically necessary)
	<input type="checkbox"/> Intensity modulated radiation therapy (IMRT)	<input type="checkbox"/> Intensity modulated radiation therapy (IMRT)	<input type="checkbox"/> Intensity modulated radiation therapy (IMRT)
	<input type="checkbox"/> Proton beam therapy	<input type="checkbox"/> Proton beam therapy	<input type="checkbox"/> Proton beam therapy
	<input type="checkbox"/> Rotational arc therapy	<input type="checkbox"/> Rotational arc therapy	<input type="checkbox"/> Rotational arc therapy
	<input type="checkbox"/> Stereotactic body radiation therapy (SBRT)	<input type="checkbox"/> Stereotactic body radiation therapy (SBRT)	<input type="checkbox"/> Stereotactic body radiation therapy (SBRT)
	<input type="checkbox"/> Tomotherapy	<input type="checkbox"/> Tomotherapy	<input type="checkbox"/> Tomotherapy
	Fractions: _____	Fractions: _____	Fractions: _____
8.	If brachytherapy is included in the treatment plan, then answer the following set of questions: a. What is the dose rate? <input type="checkbox"/> Low dose rate (LDR) <input type="checkbox"/> High dose rate (HDR)		
	b. How many fractions will be rendered?	Fractions: _____	
9.	Will the patient receive concurrent chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10.	Is the area to be treated abutting or overlapping a previously irradiated area?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11.	Will daily image-guided radiation therapy (IGRT) be used?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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12. Note any additional information in the space below:

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