

Testicular Cancer Radiation Therapy Physician Worksheet (As of 14 April 2017)

This worksheet is to be used for curative or palliative treatment of testicular cancer. If the treatment is for metastases from testicular 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 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.**

First Name:	Middle Initial:	Last Name:
DOB (mm/dd/yyyy):		Member ID:
What is the radiation therapy treatment start date (mm/dd/yyyy)?		____ / ____ / ____
1.	What is the primary histology? <input type="checkbox"/> Seminoma <input type="checkbox"/> Non-seminoma	
2.	Does the patient have distant metastases (stage M1) (i.e. to brain, lung, liver, bone)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	What is the treatment intent? <input type="checkbox"/> Postoperative (adjuvant) <input type="checkbox"/> Palliative (for relief of symptoms)	
4.	What is the clinical stage? <input type="checkbox"/> Stage I (IA or IB or IS) <input type="checkbox"/> Stage IIA or IIB <input type="checkbox"/> Stage IIC <input type="checkbox"/> Stage III (IIIA – IIIC)	
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5.	What is the treatment plan?	
	Phase I	Phase II (if applicable)
	<input type="checkbox"/> Complex (77307) <input type="checkbox"/> 3D conformal <input type="checkbox"/> Intensity modulated radiation therapy (IMRT) <input type="checkbox"/> Tomotherapy (IMRT) <input type="checkbox"/> Tomotherapy Direct / 3D <input type="checkbox"/> Rotational arc therapy <input type="checkbox"/> Proton beam therapy <input type="checkbox"/> Stereotactic body radiation therapy (SBRT)	<input type="checkbox"/> Complex (77307) <input type="checkbox"/> 3D conformal <input type="checkbox"/> Intensity modulated radiation therapy (IMRT) <input type="checkbox"/> Tomotherapy (IMRT) <input type="checkbox"/> Tomotherapy Direct / 3D <input type="checkbox"/> Rotational arc therapy <input type="checkbox"/> Proton beam therapy <input type="checkbox"/> Stereotactic body radiation therapy (SBRT)
	Number of fractions: _____	Number of fractions: _____
6.	Is the area to be treated abutting or overlapping a previously irradiated area?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Will daily image-guided radiation therapy (IGRT) be used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Note any additional information in the space below.	