



Radiation Therapy Non-Small Cell Lung Cancer Request

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.**

Patient/ Member	First Name:	Middle Initial:	Last Name:
	DOB (mm/dd/yyyy):		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Health Plan:		Member ID:

Clinical Information	ICD-10 Code(s):	
	What is the radiation therapy treatment start date (mm/dd/yyyy)?	
	<i>For best results, the answers to these questions should be submitted online.</i>	
	1.	What is the clinical T-stage? <input type="checkbox"/> TX <input type="checkbox"/> T1 <input type="checkbox"/> T2 <input type="checkbox"/> T3 <input type="checkbox"/> T4 <input type="checkbox"/> Other
	2.	What is the clinical N-stage? <input type="checkbox"/> NX <input type="checkbox"/> N0 <input type="checkbox"/> N1 <input type="checkbox"/> N2 <input type="checkbox"/> N3 <input type="checkbox"/> Other
	3.	Does the patient have distant metastases (stage M1) (i.e. to brain, lung, liver, bone)? <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	What is the treatment intent? <input type="checkbox"/> Curative, No surgery planned or performed <input type="checkbox"/> Curative, Post-operative (adjuvant) <input type="checkbox"/> Curative, Pre-operative (neo-adjuvant) <input type="checkbox"/> Curative, Treatment of the primary in an oligometastatic setting <input type="checkbox"/> Locoregional recurrence <input type="checkbox"/> Palliative (to alleviate symptoms) <input type="checkbox"/> Other: _____	
5.	Will the patient be receiving concurrent chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

Clinical Information	6.	How many fractions will be used for each phase?			
		Phase 1	Phase 2	Phase 3	Treatment Technique
					Conventional isodose planning, complex
					3D conformal
					Intensity Modulated Radiation Therapy (IMRT)
					Tomotherapy (IMRT)
					Rotational Arc Therapy/Volumetric Modulated Arc Therapy (VMAT)
					Proton Beam Therapy
					Stereotactic Body Radiation Therapy (SBRT)
					High Dose Rate (HDR) Brachytherapy
					N/A
	7.	Will image guided radiation therapy (IGRT) be used for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
	8.	If the request is for IMRT, Tomotherapy, or Rotational Arc Therapy/VMAT, has a 3D vs. IMRT comparison been completed?			
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
	<i>If yes to question 8, please complete the following and upload or fax a completed 3D/IMRT comparison plan for further review.</i>				
	9.	What is the mean lung dose with 3D conformal treatment?			
	10.	What is the mean lung dose with IMRT treatment?			
	11.	What percent of the lung is receiving 20 Gy (V20) with 3D conformal treatment?			
	12.	What percent of the lung is receiving 20 Gy (V20) with IMRT treatment?			
	13.	What is the maximum dose to the spinal cord with 3D conformal treatment?			
14.	What is the maximum dose to the spinal cord with IMRT treatment?				
15.	What is the mean heart dose with 3D conformal treatment?				
16.	What is the mean heart dose with IMRT treatment?				
<i>Please be prepared to submit consult note, results of imaging from the past 60 days and radiation prescription or clinical treatment plan in order to expedite the review process. Failure to provide all relevant information may result in a delay.</i>					
Additional Comments/Information:					