

Primary Central Nervous System (CNS) Neoplasm Radiation Therapy Physician Worksheet (As of 29 January 2020)

This worksheet is to be used for curative or palliative treatment of primary central nervous system neoplasm.

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 name:			
What is the radiation therapy treatment start date (mm/dd/yyyy)?		____ / ____ / ____	
1.	What is the patient's WHO grade or diagnosis?		
	WHO grade	<input type="checkbox"/> I: Pilocytic astrocytoma <input type="checkbox"/> II: Low grade oligo/ astrocytoma/ependymoma <input type="checkbox"/> III: Anaplastic astrocytoma <input type="checkbox"/> IV: Glioblastoma multiform (GBM)	
	Diagnosis	<input type="checkbox"/> Primary spinal tumor <input type="checkbox"/> Ependymoma <input type="checkbox"/> Recurrent primary CNS malignant tumor previously irradiated <input type="checkbox"/> Adult medulloblastoma <input type="checkbox"/> Supratentorial PNET (primitive neuroectodermal tumor) <input type="checkbox"/> Benign: Meningioma, Schwannoma, Pituitary Adenoma <input type="checkbox"/> Other: _____	
2.	What is the patient's ECOG performance status?	<input type="checkbox"/> 0	Fully active, able to carry on all pre-disease performance without restriction
		<input type="checkbox"/> 1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
		<input type="checkbox"/> 2	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.
		<input type="checkbox"/> 3	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours.
		<input type="checkbox"/> 4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.
3.	What resection has been performed?		
	<input type="checkbox"/> Biopsy only <input type="checkbox"/> Subtotal resection <input type="checkbox"/> Gross total resection <input type="checkbox"/> Other: _____		

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4.	What external beam radiation therapy technique will be used to deliver the radiation therapy? <i>Select a technique for each applicable phase, and fill in the number of fractions.</i>	
	Phase I	Phase II
	<input type="checkbox"/> Complex (77307)	<input type="checkbox"/> Complex (77307)
	<input type="checkbox"/> 3D conformal	<input type="checkbox"/> 3D conformal
	<input type="checkbox"/> Intensity modulated radiation therapy (IMRT)	<input type="checkbox"/> Intensity modulated radiation therapy (IMRT)
	<input type="checkbox"/> Tomotherapy	<input type="checkbox"/> Tomotherapy
	<input type="checkbox"/> Rotational arc therapy	<input type="checkbox"/> Rotational arc therapy
	<input type="checkbox"/> Proton beam therapy	<input type="checkbox"/> Proton beam therapy
	<input type="checkbox"/> Stereotactic body radiation therapy (SBRT)	<input type="checkbox"/> Stereotactic body radiation therapy (SBRT)
	<input type="checkbox"/> Single Fraction Stereotactic radiosurgery (SRS) (Linear Accelerator based)	<input type="checkbox"/> Single Fraction Stereotactic radiosurgery (SRS) (Linear Accelerator based)
	<input type="checkbox"/> Single Fraction Stereotactic radiosurgery (SRS) (Gamma Knife based)	<input type="checkbox"/> Single Fraction Stereotactic radiosurgery (SRS) (Gamma Knife based)
	<input type="checkbox"/> Multi-Fraction Cranial Stereotactic Radiosurgery (SRS)	<input type="checkbox"/> Multi-Fraction Cranial Stereotactic Radiosurgery (SRS)
	Number of fractions: _____	Number of fractions: _____
5.	Will the patient be receiving concurrent chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Will daily image-guided radiation therapy (IGRT) be used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Is the area to be treated abutting or overlapping a previously irradiated area?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Note any additional information in the space below:	