

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

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

Patient name:		
What is the radiation therapy treatment start date (mm/dd/yyyy)?	____ / ____ / ____	
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.	a. What is the treatment intent? <input type="checkbox"/> Pre-operative (neo-adjuvant) <input type="checkbox"/> Post-operative (adjuvant) <input type="checkbox"/> Definitive treatment <input type="checkbox"/> Palliation	
	b. If post-operative is the treatment intent, what is the pathological T stage? <input type="checkbox"/> T1 <input type="checkbox"/> T2 <input type="checkbox"/> T3 <input type="checkbox"/> T4	
	c. If post-operative is the treatment intent, what is the pathological N stage? <input type="checkbox"/> N0 <input type="checkbox"/> N1	
	d. If post-operative is the treatment intent, does the patient have any of the following risk factors? 1. Poor differentiation 2. Lymphovascular invasion 3. Perineural invasion 4. Age < 50	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Continued on next page	

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

3.	What external beam radiation therapy (EBRT) 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 1	Phase 2
	<input type="checkbox"/> Complex (77307) <input type="checkbox"/> 3D conformal <input type="checkbox"/> Intensity modulated radiation therapy (IMRT) <input type="checkbox"/> Proton beam therapy <input type="checkbox"/> Rotational arc therapy <input type="checkbox"/> Stereotactic body radiation therapy (SBRT) <input type="checkbox"/> Tomotherapy	<input type="checkbox"/> Complex (77307) <input type="checkbox"/> 3D conformal <input type="checkbox"/> Intensity modulated radiation therapy (IMRT) <input type="checkbox"/> Proton beam therapy <input type="checkbox"/> Rotational arc therapy <input type="checkbox"/> Stereotactic body radiation therapy (SBRT) <input type="checkbox"/> Tomotherapy
	Number of fractions: _____	Number of fractions: _____
4.	Will the patient receive concurrent chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Will daily image-guided radiation therapy (IGRT) be used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Note any additional information in the space below.	