

Non-Hodgkins Lymphoma Radiation Therapy Physician Worksheet (As of 26 January 2017)

This worksheet is to be used for curative or palliative treatment of Non-Hodgkin's Lymphoma. If the treatment is for metastases from Non-Hodgkin's Lymphoma, 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 start date (mm/dd/yyyy)?		____ / ____ / ____
1.		
1.	a. What is the histology?	
	<input type="checkbox"/> Indolent, such as Follicular lymphoma, MALT (including gastric, orbital) <input type="checkbox"/> Aggressive, such as Diffuse Large B-cell Lymphoma (DLBCL), Mantle cell lymphoma <input type="checkbox"/> NK/T lymphoma <input type="checkbox"/> Mycosis Fungoides (MF) <input type="checkbox"/> Primary CNS Lymphoma (PCNSL) <input type="checkbox"/> Other	
	b. If NK/T lymphoma is selected, will the patient be receiving concurrent chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. If Mycosis Fungoides is selected, is this request for total skin electron beam therapy (TSEBT)? If yes is selected, skip forward to question #7.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. If PCNSL is selected, do not continue with the Non-Hodgkin's Lymphoma worksheet. Instead, complete the CNS Lymphoma worksheet.	
2.		
2.	What is the treatment intent?	
	<input type="checkbox"/> Adjuvant (i.e. following chemotherapy) <input type="checkbox"/> Definitive <input type="checkbox"/> Salvage (Curative) <input type="checkbox"/> Palliative	
3.		
3.	What is the stage?	
	<input type="checkbox"/> Stage IA <input type="checkbox"/> Stage IIA <input type="checkbox"/> Stage IIIA <input type="checkbox"/> Stage IVA <input type="checkbox"/> Stage IB <input type="checkbox"/> Stage IIB <input type="checkbox"/> Stage IIIB <input type="checkbox"/> Stage IVB	
4.		
4.	Is treatment being directed above the diaphragm?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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5.	What is the site/location of treatment?	
	Fill in the site: _____	
6.	What is the treatment technique? <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"/> Tomotherapy <input type="checkbox"/> Stereotactic body radiation therapy (SBRT) <input type="checkbox"/> Electrons	<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"/> Tomotherapy <input type="checkbox"/> Stereotactic body radiation therapy (SBRT) <input type="checkbox"/> Electrons
	Number of fractions: _____	Number of fractions: _____
7.	If request is for total skin electron beam therapy (TSEBT), how many fractions will be rendered? See question #1c.	Number of fractions: _____
8.	Will daily image-guided radiation therapy (IGRT) be used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Note any additional information in the space below:	