

If the treatment is for metastases from a non-cancerous (not malignant) condition, 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 start date (mm/dd/yyyy)? _____ / _____ / _____																																											
1.	<p>For which diagnosis type is the member receiving radiation therapy?</p> <p>Benign cranial requests</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Acoustic neuroma (vestibular schwannoma)</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Langerhans cell histiocytosis</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> AVM (arteriovenous malformation)</td> <td style="border: none;"><input type="checkbox"/> Meningioma</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Cavernous malformation</td> <td style="border: none;"><input type="checkbox"/> Pituitary adenoma</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Chordoma</td> <td style="border: none;"><input type="checkbox"/> Other CNS benign tumor: _____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Craniopharyngioma</td> <td></td> </tr> </table> <p>Benign non-skin requests</p> <table style="width: 100%; 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	Benign cranial functional requests	
	<input type="checkbox"/> Epilepsy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Psychiatric disorders <input type="checkbox"/> Trigeminal neuralgia <input type="checkbox"/> Other CNS functional: _____	
	Benign skin requests	
	<input type="checkbox"/> Keloid scar <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other benign skin: _____	
2.	What is the treatment plan?	
	<input type="checkbox"/> External beam radiation therapy (EBRT) <input type="checkbox"/> Brachytherapy	
3.	If EBRT is the selected treatment plan, then answer the following set of questions:	
	a. What external beam radiation therapy (EBRT) technique will be used?	
	<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"/> Tomotherapy <input type="checkbox"/> Rotational arc therapy <input type="checkbox"/> Proton beam therapy <input type="checkbox"/> Superficial or Orthovoltage	<input type="checkbox"/> Stereotactic Radiosurgery (SRS) (Linear Accelerator based) <input type="checkbox"/> Stereotactic Radiosurgery (SRS) (Gamma Knife based) <input type="checkbox"/> Multi-Fraction Cranial Stereotactic Radiosurgery (SRS) <input type="checkbox"/> Stereotactic body radiation therapy (SBRT)
	b. How many fractions will be delivered?	Fractions: _____
	c. Will daily image-guided radiation therapy (IGRT) be used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	If brachytherapy is the selected treatment plan, then answer the following set of questions:	
	a. What is the dose rate?	
	<input type="checkbox"/> Low dose rate (LDR) <input type="checkbox"/> High dose rate (HDR)	
	b. How many fractions will be delivered?	Fraction: _____

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5. Note any additional information in the space below:

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