



Radiation Therapy Prostate 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)? | |
| | For best results, the answers to these questions should be submitted online. | |
| | 1. | Does the patient have a history of distant metastases (stage M1) (i.e. to brain, lung, liver, bone)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 2. | What is the treatment intent? <input type="checkbox"/> Definitive/curative (no prior surgery) <input type="checkbox"/> Oligometastases/curative <input type="checkbox"/> Post prostatectomy <input type="checkbox"/> Palliative (non-curative, to alleviate symptoms) <input type="checkbox"/> Other: _____ |
| | 3. | What was the T stage at initial diagnosis? <input type="checkbox"/> T0 <input type="checkbox"/> T2a <input type="checkbox"/> T3b <input type="checkbox"/> T1a <input type="checkbox"/> T2b <input type="checkbox"/> T4 <input type="checkbox"/> T1b <input type="checkbox"/> T2c <input type="checkbox"/> Other <input type="checkbox"/> T1c <input type="checkbox"/> T3a |
| | 4. | What is the patient's PSA level (ng/mL)? _____ ng/mL |
| | 5. | What is/was the patient's Gleason score (range: 2 to 10)? <input type="checkbox"/> <=6 <input type="checkbox"/> 8 <input type="checkbox"/> 3 + 4 = 7 <input type="checkbox"/> 9 or 10 <input type="checkbox"/> 4 + 3 = 7 <input type="checkbox"/> Unknown |
| 6. | Has the cancer spread to any of the regional lymph nodes (N1 disease)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | |
| 7. | Will the pelvic lymph nodes be treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | |

Clinical Information

| | | | | |
|----|---|---------|---------|--|
| 8. | How many fractions will be used for each phase? | | | |
| | Phase 1 | Phase 2 | Phase 3 | Treatment Technique |
| | | | | Conventional isodose planning, complex |
| | | | | Electron Beam Therapy |
| | | | | 3D conformal |
| | | | | Intensity Modulated Radiation Therapy (IMRT) |
| | | | | Tomotherapy (IMRT) |
| | | | | Rotational Arc Therapy/VMAT |
| | | | | Proton Beam Therapy |
| | | | | Stereotactic Body Radiation Therapy (SBRT) |
| | | | | Biology-guided Radiation Therapy (BgRT) |
| | | | | Low Dose Rate (LDR) Brachytherapy |
| | | | | High Dose Rate (HDR) Brachytherapy |
| | | | N/A | |

9. Will image guided radiation therapy (IGRT) be used for treatment? Yes No N/A

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.

Additional Comments/Information: