



Radiation Therapy Vulvar 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"/> Pre-operative [Continue to question 3] <input type="checkbox"/> Post-operative [Continue to question 3] <input type="checkbox"/> Definitive/curative (no prior surgery) [Continue to question 4] <input type="checkbox"/> Locoregional recurrence [Continue to question 4] <input type="checkbox"/> Palliative (non-curative, to alleviate symptoms) [Continue to question 4] <input type="checkbox"/> Other: _____ [Continue to question 4]
3.	Are any of the following risk factors present? <input type="checkbox"/> Yes <input type="checkbox"/> No 1. Close or positive margins 2. Involved lymph nodes 3. Lymphovascular invasion, extracapsular extension 4. Deep invasion, large tumor	

Clinical Information

4.	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/Volumetric Modulated 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	
5.	Will image guided radiation therapy (IGRT) be used for treatment?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6.	Will the patient be receiving concurrent chemotherapy?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
7.	If Brachytherapy was selected, what is the implant type?			
	<input type="checkbox"/> Ovoids only <input type="checkbox"/> Tandem only <input type="checkbox"/> Tandem and ovoids <input type="checkbox"/> Vaginal cylinder only <input type="checkbox"/> Interstitial			
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:				