Testicular Cancer
Radiation Therapy Physician Worksheet

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

First Name:	**Middle Initial:**	**Last Name:**
DOB (mm/dd/yyyy):	**Member ID:**	
What is the radiation therapy treatment start date (mm/dd/yyyy)?	_____ /_____ /_____	

1.	What is the primary histology? ☐ Seminoma ☐ Non-seminoma	
2.	Does the patient have distant metastases (stage M1) (i.e. to brain, lung, liver, bone)?	☐ Yes ☐ No
3.	What is the treatment intent? ☐ Postoperative (adjuvant) ☐ Palliative (for relief of symptoms)	
4.	What is the clinical stage? ☐ Stage I (IA or IB or IS) ☐ Stage IIA or IIB ☐ Stage IIC ☐ Stage III (IIIA – IIIC)	

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5.	What is the treatment plan?	
	Phase I	Phase II (if applicable)
	☐ Conventional isodose planning, complex ☐ 3D conformal ☐ Intensity modulated radiation therapy (IMRT) ☐ Tomotherapy (IMRT) ☐ Tomotherapy Direct / 3D ☐ Rotational arc therapy ☐ Proton beam therapy ☐ Stereotactic body radiation therapy (SBRT) ☐ Biology-guided Radiation Therapy (BgRT)	☐ Conventional isodose planning, complex ☐ 3D conformal ☐ Intensity modulated radiation therapy (IMRT) ☐ Tomotherapy (IMRT) ☐ Tomotherapy Direct / 3D ☐ Rotational arc therapy ☐ Proton beam therapy ☐ Stereotactic body radiation therapy (SBRT) ☐ Biology-guided Radiation Therapy (BgRT)
	Number of fractions: _____	Number of fractions: _____
6.	Is the area to be treated abutting or overlapping a previously irradiated area?	☐ Yes ☐ No
7.	Will daily image-guided radiation therapy (IGRT) be used?	☐ Yes ☐ No
8.	Note any additional information in the space below.	