

This worksheet is to be used for curative or palliative treatment of gallbladder cancer. If the treatment is for metastases from gallbladder 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.	Does the patient have 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"/> Palliative <input type="checkbox"/> Post-operative (adjuvant) <input type="checkbox"/> Definitive <input type="checkbox"/> Pre-operative (neo-adjuvant)	
3.	If post-operative is the treatment intent, then answer the following questions:	
	a. What is the clinical T stage?	
	<input type="checkbox"/> T0 <input type="checkbox"/> T3 <input type="checkbox"/> T1 <input type="checkbox"/> T4 <input type="checkbox"/> T2 <input type="checkbox"/> Tis	
	b. What is the nodal status?	
	<input type="checkbox"/> N0 <input type="checkbox"/> N1 <input type="checkbox"/> N2	
	c. What is the resection margin status?	
	<input type="checkbox"/> Negative margins <input type="checkbox"/> Positive margins <input type="checkbox"/> N/A	
4.	What technique will be used to deliver the radiation therapy?	
	<input type="checkbox"/> External beam radiation therapy (EBRT) <input type="checkbox"/> Brachytherapy <input type="checkbox"/> Selective internal radiation therapy (SIRT)	
Continued on next page		

5.	If EBRT is the selected treatment, then answer the following questions:	
	a. What EBRT technique will be used to deliver the radiation therapy? <i>Select a technique for each applicable phase, and fill in the number of fractions.</i>	
	Phase I	Phase II
	<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"/> Stereotactic body radiation therapy (SBRT)	<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"/> Stereotactic body radiation therapy (SBRT)
	Number of fractions: _____	Number of fractions: _____
	b. If a form of IMRT was selected, was 3D conformal technique considered?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Will daily Image-guided radiation therapy (IGRT) be used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	If brachytherapy is the selected treatment, then answer the following questions:	
	a. What is the dose rate?	
	<input type="checkbox"/> Low Dose Rate <input type="checkbox"/> High Dose Rate	
	b. How many applications will be used?	Applications: _____
7.	If SIRT is the selected treatment plan, how many treatments will be utilized?	Treatments: _____
8.	Will the patient receive concurrent chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Note any additional information in the space below. <i>If SIRT or other brachytherapy technique will be used, provide details and rationale for selection of the SIRT or brachytherapy.</i>	