

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 start date (mm/dd/yyyy)?		____ / ____ / ____

If your request is for Radiopharmaceuticals, please use the appropriate worksheet.

1.	What is the primary diagnosis?	
	<input type="checkbox"/> Adrenal Cancer <input type="checkbox"/> Anal Cancer <input type="checkbox"/> Bile Duct Cancer <input type="checkbox"/> Bladder Cancer <input type="checkbox"/> Bone Metastases <input type="checkbox"/> Brain Metastases <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Cervical Cancer <input type="checkbox"/> CNS Lymphoma <input type="checkbox"/> CNS Neoplasm <input type="checkbox"/> Endometrial Cancer <input type="checkbox"/> Esophagus Cancer <input type="checkbox"/> Gallbladder Cancer <input type="checkbox"/> Gastric (Stomach) Cancer <input type="checkbox"/> Head and Neck Cancer <input type="checkbox"/> Hepatobiliary Cancer <input type="checkbox"/> Hodgkin's Lymphoma	<input type="checkbox"/> Kidney Cancer <input type="checkbox"/> Liver Cancer <input type="checkbox"/> Lung Cancer – Non Small Cell <input type="checkbox"/> Lung Cancer – Small Cell <input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> Non-Cancerous Diagnosis <input type="checkbox"/> Oligometastases <input type="checkbox"/> Pancreatic Cancer <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Rectal Cancer <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Soft Tissue Sarcoma <input type="checkbox"/> Testicular Cancer <input type="checkbox"/> Urethral and Ureteral Cancer <input type="checkbox"/> Vulva Cancer <input type="checkbox"/> Metastases (Non-Bone/Brain) <input type="checkbox"/> Other

If Other was not selected, please stop and fill out the appropriate physician worksheet.

2.	Please specify the primary diagnosis: _____
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3.	a. What is the patient's ECOG performance status?	<input type="checkbox"/> 0	Fully active, able to carry on all pre-disease performance without restriction.
		<input type="checkbox"/> 1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
		<input type="checkbox"/> 2	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.
		<input type="checkbox"/> 3	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours.
		<input type="checkbox"/> 4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.
b. If the ECOG status is due to the cancer, is the status expected to improve with radiation therapy treatment?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

4.	Does the patient have distant metastases (stage M1) (i.e. to brain, lung, liver, bone)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If the diagnosis is brain or bone metastases, stop and use the brain or bone metastases worksheet.

5.	<p>a. What is the intent of treatment?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Initial primary treatment</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Isolated <u>local</u> recurrence at primary or adjacent site</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Pre-operative radiation</td> <td style="border: none;"><input type="checkbox"/> Palliation of metastatic site - <i>explain below in question #5b</i></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Post-operative radiation</td> <td style="border: none;"><input type="checkbox"/> Other - <i>explain below in question #5b</i></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Palliation at primary site</td> <td></td> </tr> </table> <p>b. If intent of treatment is "palliation of metastatic site" or "other", then use the space below to list the metastatic sites to be treated and to explain the treatment intent in further detail.</p>	<input type="checkbox"/> Initial primary treatment	<input type="checkbox"/> Isolated <u>local</u> recurrence at primary or adjacent site	<input type="checkbox"/> Pre-operative radiation	<input type="checkbox"/> Palliation of metastatic site - <i>explain below in question #5b</i>	<input type="checkbox"/> Post-operative radiation	<input type="checkbox"/> Other - <i>explain below in question #5b</i>	<input type="checkbox"/> Palliation at primary site	
<input type="checkbox"/> Initial primary treatment	<input type="checkbox"/> Isolated <u>local</u> recurrence at primary or adjacent site								
<input type="checkbox"/> Pre-operative radiation	<input type="checkbox"/> Palliation of metastatic site - <i>explain below in question #5b</i>								
<input type="checkbox"/> Post-operative radiation	<input type="checkbox"/> Other - <i>explain below in question #5b</i>								
<input type="checkbox"/> Palliation at primary site									

If treatment intent is "palliation at metastatic site", "palliation at primary site" or "other" (see question #5a), skip forward to question #9. Otherwise, continue forward to question #6

6.	<p>a. What is the clinical stage?</p> <p style="text-align: center;"><input type="checkbox"/> T1 <input type="checkbox"/> T2 <input type="checkbox"/> T3 <input type="checkbox"/> T4 <input type="checkbox"/> Unknown</p> <p>b. Nodes:</p> <p style="text-align: center;"><input type="checkbox"/> N0 <input type="checkbox"/> N1 <input type="checkbox"/> N2 <input type="checkbox"/> N3 <input type="checkbox"/> Nx</p>
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7.	Is the area to be treated abutting or overlapping a previously irradiated area?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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8.	Will the patient receive concurrent chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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9.	a. What is the treatment plan?	
	<input type="checkbox"/> External beam radiation therapy (EBRT) <input type="checkbox"/> Selective internal radiation therapy (SIRT) <input type="checkbox"/> Brachytherapy <input type="checkbox"/> Brachytherapy and EBRT	
	b. If SIRT is the selected treatment plan, how many treatments will be used?	Treatments: _____

If "Selective internal radiation therapy (SIRT)" is the selected treatment plan, skip forward to question #12. Otherwise, continue forward to question #10

10.	If EBRT is included in the treatment plan, then answer the following set of questions:		
	a. What is the EBRT technique? <i>Select a technique for each applicable phase, and fill in the number of fractions</i>		
	Phase 1	Phase II	Phase III
	<input type="checkbox"/> Complex (77307)	<input type="checkbox"/> Complex (77307)	<input type="checkbox"/> Complex (77307)
	<input type="checkbox"/> 3D conformal	<input type="checkbox"/> 3D conformal	<input type="checkbox"/> 3D conformal
	<input type="checkbox"/> Electrons	<input type="checkbox"/> Electrons	<input type="checkbox"/> Electrons
	<input type="checkbox"/> Intensity modulated radiation therapy (IMRT)	<input type="checkbox"/> Intensity modulated radiation therapy (IMRT)	<input type="checkbox"/> Intensity modulated radiation therapy (IMRT)
	<input type="checkbox"/> Rotational arc therapy	<input type="checkbox"/> Rotational arc therapy	<input type="checkbox"/> Rotational arc therapy
	<input type="checkbox"/> Proton beam therapy	<input type="checkbox"/> Proton beam therapy	<input type="checkbox"/> Proton beam therapy
	<input type="checkbox"/> Tomotherapy	<input type="checkbox"/> Tomotherapy	<input type="checkbox"/> Tomotherapy
	<input type="checkbox"/> Stereotactic body radiation therapy (SBRT)	<input type="checkbox"/> Stereotactic body radiation therapy (SBRT)	<input type="checkbox"/> Stereotactic body radiation therapy (SBRT)
	<input type="checkbox"/> Single Fraction Stereotactic radiosurgery (SRS) (Linear Accelerator based)	<input type="checkbox"/> Single Fraction Stereotactic radiosurgery (SRS) (Linear Accelerator based)	<input type="checkbox"/> Single Fraction Stereotactic radiosurgery (SRS) (Linear Accelerator based)
	<input type="checkbox"/> Single Fraction Stereotactic radiosurgery (SRS) (Gamma Knife based)	<input type="checkbox"/> Single Fraction Stereotactic radiosurgery (SRS) (Gamma Knife based)	<input type="checkbox"/> Single Fraction Stereotactic radiosurgery (SRS) (Gamma Knife based)
	Number of fractions: _____	Number of fractions: _____	Number of fractions: _____
	b. Will daily image-guided radiation therapy (IGRT) be used?		<input type="checkbox"/> Yes <input type="checkbox"/> No

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Other Cancer Type Radiation Therapy Physician Worksheet (As of 29 January 2020)

11.	If brachytherapy is included in the 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 applications will be used?	Applications: _____

12.	Note any additional information in the space below:
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