

Soft Tissue Sarcoma Radiation Therapy Worksheet (As of 19 January 2018)

This worksheet is to be used for curative or palliative treatment of soft tissue sarcoma. If the treatment is for metastases from soft tissue sarcoma, 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.	Where is the soft tissue sarcoma located?		
2.	What is the intent of treatment?		
<input type="checkbox"/> Palliative, for relief of symptoms <input type="checkbox"/> Definitive, biopsy only and no resection completed or planned <input type="checkbox"/> Pre-operative, resection planned after pre-operative radiation <input type="checkbox"/> Borderline resectable, neoadjuvant radiation to convert from unresectable to resectable <input type="checkbox"/> Post-operative, resection performed no pre-radiation given <input type="checkbox"/> Post-operative, pre-operative radiation was given <input type="checkbox"/> Re-treatment of localized recurrent disease with curative, salvage intent			
3.	a. What is the T stage?		T stage: _____
	b. What is the N stage?		N stage: _____
	c. 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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4.	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.

5.	What treatment will be used?
<input type="checkbox"/> External beam radiation therapy (EBRT) <input type="checkbox"/> Brachytherapy <input type="checkbox"/> Brachytherapy and EBRT	

6.	If EBRT is being used, what is the treatment plan?			
	<i>Select a technique for each applicable phase and fill in the number of fractions.</i>			
		Phase 1	Phase 2	Phase 3
	<input type="checkbox"/>	3D conformal	<input type="checkbox"/>	3D conformal
	<input type="checkbox"/>	Complex (77307)	<input type="checkbox"/>	Complex (77307)
	<input type="checkbox"/>	Intensity modulated radiation therapy (IMRT)	<input type="checkbox"/>	Intensity modulated radiation therapy (IMRT)
	<input type="checkbox"/>	Proton beam therapy	<input type="checkbox"/>	Proton beam therapy
	<input type="checkbox"/>	Rotational arc therapy	<input type="checkbox"/>	Rotational arc therapy
	<input type="checkbox"/>	Stereotactic body radiation therapy (SBRT)	<input type="checkbox"/>	Stereotactic body radiation therapy (SBRT)
	<input type="checkbox"/>	Tomotherapy	<input type="checkbox"/>	Tomotherapy
	Fractions: _____	Fractions: _____	Fractions: _____	

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7.	If brachytherapy is being used, 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. If HDR, how many fractions will be rendered?	Fractions: _____
c. If HDR, how many applications will be used?	Applications: _____	
8.	Is the area to be treated abutting or overlapping a previously irradiated area?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Will daily image-guided radiation therapy (IGRT) be used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Note any additional information in the space below:	