

This worksheet is to be used for curative or palliative treatment of ureter/urethral cancer. If the treatment is for metastases from ureter/urethral 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.	Which primary site is being treated?	
	<input type="checkbox"/> Urethra <input type="checkbox"/> Ureter	
2.	Does the patient have distant metastases (stage M1) (i.e. to brain, lung, liver, bone)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	What is the treatment intent?	
	<input type="checkbox"/> Pre-operative (neo-adjuvant) <input type="checkbox"/> Definitive (no surgery planned) <input type="checkbox"/> Post-operative (adjuvant) <input type="checkbox"/> Palliative (for relief of symptoms)	
4.	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	
5.	What is the nodal status?	
	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> N/A	
6.	If the patient has undergone surgical resection, what was the surgical margin status?	
	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> N/A	

Continued on the next page

7.	What external beam radiation therapy 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 (if applicable)
	<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: _____
8.	Will the patient receive concurrent chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	a. Will daily image-guided radiation therapy (IGRT) be used for phase I?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Will IGRT be used for phase II?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Note any additional information in the space below.	