Radiation Therapy Extra-Cranial Metastases Request

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.**

Patient/ Member

First Name:	Middle Initial:	Last Name:
DOB *(mm/dd/yyyy)*:		Gender: ☐ Male ☐ Female
Health Plan:		Member ID:

Clinical Information

ICD-10 Code(s):

What is the radiation therapy treatment start date *(mm/dd/yyyy)*?

eviCore is utilizing a clinical decision support submission model for this diagnosis. Please note that only some of the following example questions will need to be answered during the submission of your prior authorization request. For best results, the answers to these questions should be submitted online.

What is the location of the metastatic site(s) that will be treated? Please specify the spine levels and/or other location for the metastatic site(s) if applicable.

Site 1	Site 2	Site 3	Site 4	Location
				Adrenal gland
				Bone
				Lung
				Liver
				Spine
				Other Non-Bone

Please specify the spine levels, bone location and/or the Other Non-Bone location for the metastatic site(s), if applicable.

If there are more than 4 metastatic sites, please provide the location(s) of the additional metastatic site(s).

Clinical Information

How many fractions will be used for each metastatic site(s)?

Site 1	Site 2	Site 3	Site 4	Treatment Technique
				Conventional isodose planning, complex
				Electron Beam Therapy
				3D conformal
				Tomotherapy Direct/3D
				Intensity Modulated Radiation Therapy (IMRT)
				Tomotherapy (IMRT)
				Rotational Arc Therapy
				Proton Beam Therapy
				Stereotactic Body Radiation Therapy (SBRT)

Please provide the treatment technique and number of fractions for the additional metastatic site(s) being treated, if applicable.

Will image guided radiation therapy (IGRT) be used for the initial phase? ☐ Yes ☐ No ☐ N/A

Was any area being treated previously irradiated? ☐ Yes ☐ No ☐ N/A

If more than one site, will radiation to the metastatic sites be delivered concurrently? ☐ Yes ☐ No

If more than one site, will the same treatment technique be used for all metastatic sites? ☐ Yes ☐ No

Please be prepared to submit consult note, results of imaging from the past 60 days and radiation prescription or clinical treatment plan in order to expedite the review process. Failure to provide all relevant information may result in a delay in case processing.

Additional Comments/Information: