



Radiation Therapy Head and Neck Cancer 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: <input type="checkbox"/> Male <input type="checkbox"/> 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 head and neck site being treated?
	<input type="checkbox"/> Lip <input type="checkbox"/> Oral cavity (e.g. floor of mouth) <input type="checkbox"/> Oropharynx (p16 negative) (e.g. base of tongue, tonsil) <input type="checkbox"/> Oropharynx (p16 positive) (e.g. base of tongue, tonsil) <input type="checkbox"/> Hypopharynx <input type="checkbox"/> Nasopharynx <input type="checkbox"/> Glottic Larynx (vocal cords only) <input type="checkbox"/> Supraglottic Larynx <input type="checkbox"/> Nasal cavity <input type="checkbox"/> Ethmoid sinus <input type="checkbox"/> Maxillary sinus <input type="checkbox"/> Salivary gland (e.g. parotid) <input type="checkbox"/> Unknown primary <input type="checkbox"/> Other _____
	What is the treatment intent?
<input type="checkbox"/> Curative, No surgery planned or performed without metastatic disease <input type="checkbox"/> Curative, Post-operative (adjuvant) without metastatic disease <input type="checkbox"/> Curative, Pre-operative (neo-adjuvant) without metastatic disease <input type="checkbox"/> Curative, treatment of the primary in an oligometastatic setting <input type="checkbox"/> Loco-regional Recurrence without metastatic disease <input type="checkbox"/> Palliative <input type="checkbox"/> Other _____	

Clinical Information

If Glottis Larynx, what is the stage?

- | | |
|---|---|
| <input type="checkbox"/> In-situ (TisN0) | <input type="checkbox"/> IVA (T4a and/or N2) |
| <input type="checkbox"/> I (T1N0) | <input type="checkbox"/> IVB (T4b and/or N3) |
| <input type="checkbox"/> II (T2N0) | <input type="checkbox"/> IVC (distant metastasis) |
| <input type="checkbox"/> III (T1-2N1 or T3N0-1) | |

How many fractions will be used for each phase?

Phase 1	Phase 2	Phase 3	Treatment Technique
			Electron Beam Therapy
			3D conformal
			Intensity Modulated Radiation Therapy (IMRT)
			Tomotherapy (IMRT)
			Rotational Arc Therapy
			Proton Beam Therapy
			Stereotactic Body Radiation Therapy (SBRT)
			Low Dose Rate (LDR) Brachytherapy
			High Dose Rate (HDR) Brachytherapy
			N/A

Will image guided radiation therapy (IGRT) be used for treatment? Yes No N/A

Will concurrent chemotherapy be used for this course of treatment? Yes No N/A

Is twice a day treatment planned for any or all of the course of treatment? Yes No N/A

Has the patient received prior radiation to this area? Yes No N/A

If Proton was selected, what technique of Protons will you be using?

- Intensity Modulated Proton Therapy (IMRT) (using IMRT planning)
- Passive Scattering Proton Therapy (using 3D planning)

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.

Additional Comments/Information:

