



Radiation Therapy Brain 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: <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)?												
	<i>For best results, the answers to these questions should be submitted online.</i>												
	1.	What is the treatment plan? <input type="checkbox"/> Whole Brain Radiation Therapy (WBRT) <input type="checkbox"/> Hippocampal Avoidance Whole Brain Radiation Therapy (HA-WBRT) <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"/> Multi-Fraction Stereotactic Radiosurgery (SRS) <input type="checkbox"/> Other (including proton based therapies)											
	2.	What is the primary diagnosis? <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Breast</td> <td><input type="checkbox"/> Sarcoma</td> </tr> <tr> <td><input type="checkbox"/> Colorectal</td> <td><input type="checkbox"/> Kidney (renal cell)</td> </tr> <tr> <td><input type="checkbox"/> Head and Neck</td> <td><input type="checkbox"/> Testicular</td> </tr> <tr> <td><input type="checkbox"/> Non-small cell lung (NSLC)</td> <td><input type="checkbox"/> Thyroid</td> </tr> <tr> <td><input type="checkbox"/> Small cell (lung or extra-pulmonary)</td> <td><input type="checkbox"/> Lymphoma</td> </tr> <tr> <td><input type="checkbox"/> Melanoma</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table>	<input type="checkbox"/> Breast	<input type="checkbox"/> Sarcoma	<input type="checkbox"/> Colorectal	<input type="checkbox"/> Kidney (renal cell)	<input type="checkbox"/> Head and Neck	<input type="checkbox"/> Testicular	<input type="checkbox"/> Non-small cell lung (NSLC)	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Small cell (lung or extra-pulmonary)	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Melanoma
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<input type="checkbox"/> Melanoma	<input type="checkbox"/> Other: _____												
3.	Does the patient have leptomeningeal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No												

Questions 4-8 are only applicable when question 1 is single fraction SRS, multi-fraction SRS, or Other.

Otherwise please continue to question 9.

4.	Has the patient ever had radiation to the brain before? <input type="checkbox"/> Yes <input type="checkbox"/> No [continue to question 6]		
5.	If patient has had prior radiation to the brain, please specify the prior radiation: <input type="checkbox"/> Whole brain radiation therapy (WBRT) <input type="checkbox"/> SRS/FSRT <input type="checkbox"/> Both		
6.	How many lesions are present in the brain? _____		
7.	<p align="center">For single fraction SRS, all lesions should be treated within a single fraction. For all multi-fraction SRS, all lesions should be treated within 5 fractions (treatment sessions).</p> Will you be requesting an additional authorization to treat any additional brain lesions? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8.	Is there treatment planned to any sites outside of the brain? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9.	How many fractions will be used for each phase?		
	Phase 1	Phase 2	Phase 3
			Treatment Technique
			Conventional isodose planning, complex
			3D conformal
			Intensity Modulated Radiation Therapy (IMRT)
			Tomotherapy (IMRT)
			Rotational Arc Therapy
			Proton Beam Therapy
			Stereotactic Body Radiation Therapy (SRS) (Linear Accelerator based)
			Stereotactic Body Radiation Therapy (SRS) (Gamma Knife based)
			Multi-Fraction Stereotactic Body Radiation Therapy (SRS)
10.	Will image guided radiation therapy (IGRT) be used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		

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:

Clinical Information