

Radiation Therapy Breast 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)?			
	For best results, the answers to these questions should be submitted online.			
	1.	Which breast will be treated? <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> N/A		
	2.	If Bilateral, will treatment be delivered concurrently to both breasts? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
	3.	What is the T stage? <i>If bilateral, T stage will be needed for both breasts.</i> <input type="checkbox"/> TX <input type="checkbox"/> Tis (DCIS) <input type="checkbox"/> T0 <input type="checkbox"/> T1 <input type="checkbox"/> T2 <input type="checkbox"/> T3 <input type="checkbox"/> T4		
	4.	What is the N stage? <i>If bilateral, N stage will be needed for both breasts.</i> <input type="checkbox"/> NX <input type="checkbox"/> N0 <input type="checkbox"/> N1 <input type="checkbox"/> N2 <input type="checkbox"/> N3		
	5.	Does the patient have a history of distant metastases (stage M1) (i.e. to brain, lung, liver, bone)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	6.	What is the treatment plan? <input type="checkbox"/> Whole breast radiation <u>without</u> regional nodal radiation [Continue to question 9] <input type="checkbox"/> Whole breast radiation <u>with</u> regional nodal radiation (i.e., axillary, supraclavicular, and/or internal mammary nodes) [Continue to question 7] <input type="checkbox"/> Partial breast irradiation (PBI) [Continue to question 9] <input type="checkbox"/> Accelerated partial breast irradiation (APBI) [Continue to question 9] <input type="checkbox"/> Intraoperative radiation therapy (IORT) [Continue to question 9] <input type="checkbox"/> Post-mastectomy radiation therapy (PMRT) [Continue to question 7] <input type="checkbox"/> Metastatic breast cancer to treat with locoregional radiation therapy [Continue to question 9] <input type="checkbox"/> Palliative [Continue to question 9] <input type="checkbox"/> Other: _____ [Continue to question 9]		
	7.	Will treatment include the supraclavicular nodes? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
8.	Will treatment include the internal mammary nodes? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			

Clinical Information	9.	How many fractions will be used for each phase?			
	Phase 1	Phase 2	Phase 3	Treatment Technique	
				Conventional isodose planning, complex	
				Electron Beam Therapy	
				3D conformal	
				Intensity Modulated Radiation Therapy (IMRT)	
				Tomotherapy (IMRT)	
				Rotational Arc Therapy/Volumetric Modulated Arc Therapy (VMAT)	
				Proton Beam Therapy	
				Stereotactic Body Radiation Therapy (SBRT)	
				Electrons	
				Biology-guided Radiation Therapy (BgRT)	
				Low Dose Rate (LDR) Brachytherapy	
				High Dose Rate (HDR) Brachytherapy	
				AccuBoost	
				Electronic brachytherapy (HDR)	
				Electron Beam IORT (i.e. Mobetron)	
				Low-Energy X-Ray IORT (i.e. IntraBeam)	
				Electronic Brachytherapy IORT (i.e. Xofig or Axxent)	
				N/A	
10.	Will image guided radiation therapy (IGRT) be used for the first phase?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
11.	Will respiratory motion tracking be used?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
12.	How will the patient be treated?			<input type="checkbox"/> Supine <input type="checkbox"/> Prone <input type="checkbox"/> N/A	
13.	Will image guided radiation therapy (IGRT) be used for the second phase?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
14.	Will image guided radiation therapy (IGRT) be used for the third phase?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
15.	If the request is for Accelerated partial breast irradiation (APBI), will the treatment be delivered twice daily (i.e. BID)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
16.	If the request is for IMRT, Tomotherapy, or Rotational Arc Therapy/VMAT, has a 3D vs. IMRT comparison been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				

Clinical Information	<i>If yes to question 16, please complete the following and upload or fax a completed 3D/IMRT comparison plan for further review.</i>	
	17.	What is the mean heart dose with 3D conformal treatment?
	18.	What is the mean heart dose with IMRT treatment?
	19.	What percentage of the ipsilateral lung is receiving 20 Gy(V20) with 3D conformal treatment?
	20.	What percentage of the ipsilateral lung is receiving 20 Gy(V20) with IMRT treatment?
	<i>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.</i>	
	Additional Comments/Information:	