Prior Authorization for Therapeutic Radiation Procedures Including Intensity Modulation Radiation Treatment (IMRT), Stereotactic Radio Surgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)

This worksheet is a tool to help you identify and collect the clinical information required to support a prior authorization request for Medicare Advantage members. After the clinician completes the clinical information, please go to UHCprovider.com > Prior Authorization and Notification > Oncology > Medicare Advantage Therapeutic Radiation to submit the prior authorization request. Submitting the clinical information from this worksheet alone won’t automatically result in prior authorization approval. If you have questions about prior authorization submissions or need to request an expedited review, please call UnitedHealthcare Clinical Requests at 866-889-8054.

Member name: _____________________________________________

Please provide the radiation therapy treatment start date (MM/DD/YYYY): _______ / ______ / ______

1. What is the site of the primary cancer? (select all that apply)
   - [ ] Bladder
   - [ ] Colorectal
   - [ ] Liver
   - [ ] Pancreas
   - [ ] Breast
   - [ ] Head/Neck
   - [ ] Lung
   - [ ] Prostate
   - [ ] Other: _______________________
   - [ ] Cervix/Endometrium
   - [ ] Kidney
   - [ ] Melanoma
   - [ ] Sarcoma

2. Is this a solitary bone metastasis? □ Yes □ No
2a. If this is not a solitary bone metastasis, are there fewer than 5 bone lesions? □ Yes □ No

3. Does the member have brain or visceral (lung, liver, adrenal) metastases present? □ Yes □ No

4. What is/are the location(s) of the metastasis(es) to be treated? □ Spine □ Non-spine
4a. If yes to spine, is there spinal cord compression? □ Yes □ No

5. What is the member’s ECOG performance status? (select one only)
   - [ ] 0 - Fully active, able to carry on all pre-disease performance without restriction.
   - [ ] 1 - Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
   - [ ] 2 - Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.
   - [ ] 3 - Capable of only limited self-care, confined to bed or chair more than 50% of waking hours.
   - [ ] 4 - Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.

Continued on next page
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<td>6.</td>
<td>Is the performance status expected to improve as a result of this treatment?</td>
<td>☐ Yes ☐ No</td>
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<td>7.</td>
<td>Is the area to be treated abutting, within, or overlapping an area that has been previously treated with radiation therapy?</td>
<td>☐ Yes ☐ No</td>
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<td>8.</td>
<td>What is the treatment technique being requested? (select one only)</td>
<td>☐ IMRT ☐ SBRT (up to 5 treatment fractions) ☐ Other: ____________________________</td>
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<td>9.</td>
<td>Please note any additional information below.</td>
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