Physician Worksheet for Breast Cancer
Medicare Advantage Prior Authorization Request

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](http://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:**

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<table>
<thead>
<tr>
<th>Please provide the radiation therapy treatment start date (MM/DD/YYYY):</th>
<th>_______ / _______ / _______</th>
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1. **Will the treatment be directed to the primary site?**
   - Yes
   - No

   **Do not proceed if treatment is being directed to a metastatic site, such as bone, brain, liver, or lung. Instead, complete the appropriate worksheet for the metastatic site.**

2. **Does the member have distant metastatic disease?**
   - Yes
   - No

3. **What treatment plan will be executed for the initial phase? (select one only)**
   - Whole breast
   - Chest wall radiotherapy
   - Partial breast radiotherapy

4. **Will you be treating the internal mammary lymph nodes?**
   - Yes
   - No

4a. **Is the mid-tangential treatment separation greater than 25.5 cm?**
   - Yes
   - No

4b. **Is the member’s bra cup size D or greater?**
   - Yes
   - No

5. **Is the area to be treated abutting, within, or overlapping an area that has been previously treated with radiation therapy?**
   - Yes
   - No

6. **What is the treatment technique being requested? (select one only)**
   - Inverse planned IMRT
   - SBRT (up to 5 treatment fractions)
   - SBRT boost
   - Other: ____________________________

Continued on next page
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| 7. | Have you considered a forward planned (segmental, field in field) IMRT treatment plan for the member? | □ Yes □ No |

| 8. | Please note any additional information below. |   |