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 UnitedHealthcare 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; additional clinical information may be requested during the clinical review process. If you have questions about your submission or need to request an expedited review, please call 866-889-8054.

Patient/ Member			
	First Name:	Middle Initial:	Last Name:
	DOB *(mm/dd/yyyy)*:		Gender: ☐ Male ☐ Female
	Health Plan:		Member ID:

Clinical Information				
	ICD-10 Code(s):			
	What is the radiation therapy treatment start date *(mm/dd/yyyy)*?			
	Please have the answers to below questions prepared as these questions may be asked.			
	What is the treatment plan?			
	☐ Whole breast radiation without regional nodal radiation ☐ Partial breast irradiation (PBI) without regional nodal radiation ☐ Whole breast radiation with regional nodal radiation (i.e., axillary, supraclavicular, and/or internal mammary nodes) ☐ Treatment of bilateral breast cancer ☐ Post-mastectomy radiation therapy (PMRT) ☐ Accelerated partial breast irradiation (APBI) ☐ Intraoperative radiation therapy (IORT) ☐ Radiation to the breast or chest wall with or without regional nodal radiation in a patient with local recurrence only and no distant metastatic disease ☐ Radiation to the breast or chest wall with or without regional nodal radiation in a patient with a history of distant metastatic disease (e.g. to the brain, lung, liver, and/or bone) ☐ Re-irradiation of the breast or chest wall with or without regional nodal radiation ☐ Palliative radiation therapy to the breast or chest wall with or without regional nodal radiation			
	What is the stage?			
	☐ T1mi N0	☐ T1c N0	☐ T4a N0	☐ T4d N0
	☐ T1a N0	☐ T2 N0	☐ T4b N0	☐ Ductal Carcinoma In Situ (DCIS)
	☐ T1b N0	☐ T3 N0	☐ T4c N0	☐ Other: _____

Clinical Information

What treatment technique will be used?

- ☐ Intensity Modulated Radiation Therapy (IMRT)
- ☐ Stereotactic Body Radiation Therapy (SBRT)

Does the patient meet the following “Suitable” criteria (as defined in the ASTRO consensus statement for APBI and by NCCN®)?

- ☐ Invasive Tumors - Patient is BRCA-negative; Tumor is ER-positive with negative margins of at least 2 mm and without lymphovascular invasion (LVI)
- ☐ In Situ Tumors - Tumor was detected by screening, is low or intermediate grade, is ≤2.5 cm and has negative margins of at least 3 mm
- ☐ None of the above

What side of the breast will be treated?	☐ Bilateral	☐ Left	☐ Right
Will treatment include the supraclavicular nodes?	☐ Yes	☐ No	☐ N/A
Will treatment include the internal mammary nodes?	☐ Yes	☐ No	☐ N/A

Additional Comments/Information: