Physician Worksheet for Hodgkin & Non-Hodgkin’s Lymphoma
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.

<table>
<thead>
<tr>
<th>Member name:</th>
<th></th>
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<tbody>
<tr>
<td>Please provide the radiation therapy treatment start date (MM/DD/YYYY):</td>
<td>_____ / _____ / _____</td>
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1. What type of lymphoma does the member have?
   - [ ] Hodgkin’s Lymphoma
   - [ ] Non-Hodgkin’s Lymphoma

2. What regions will be treated? (select all that apply)
   - [ ] Head/neck
   - [ ] Thorax
   - [ ] Abdomen
   - [ ] Pelvis
   - [ ] Other: ____________________________

   **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.**

3. Does the member have disease outside the radiation portal?  
   - [ ] Yes  
   - [ ] No

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

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

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6. What is the intended total radiation dose?
   - □ Less than or equal to 30 Gy
   - □ Greater than 30 Gy

7. Did you consider 3D, including Tomo3D, for the member?  □ Yes □ No

8. Please note any additional information below.

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