We provide this form to care providers who have UnitedHealthcare members undergoing Intensity Modulated Radiation Therapy (IMRT). To reduce and avoid delays for IMRT services, the clinician treating the UnitedHealthcare member will need to complete the requested information on this form. Follow the instructions on the corresponding IMRT prior authorization request cover sheet to submit your request. Thank you.

### Patient name: __________________________

Please provide the radiation therapy treatment start date (MM/DD/CCYY): ______/_____/____

1. What is the site of the primary cancer? (Please check the appropriate box(es))
   - [ ] Bladder
   - [ ] Breast
   - [ ] Cervix/Endometrium
   - [ ] Colorectal
   - [ ] Head/Neck
   - [ ] Kidney
   - [ ] Lung
   - [ ] Melanoma
   - [ ] Pancreas
   - [ ] Prostate
   - [ ] Sarcoma
   - [ ] Other

2. Is this a solitary bone metastasis without any visceral (e.g., liver, lung, adrenal) metastases? [ ] Yes [ ] No

3. What is/are the location(s) of the metastasis(es) to be treated?
   - [ ] Femur
   - [ ] Humerus
   - [ ] Pelvis
   - [ ] Rib
   - [ ] Shoulder
   - [ ] Skull
   - [ ] Spine
   - [ ] Other (please specify) ________________________

4. Check boxes for all that apply.
   - [ ] Palliation of pain
   - [ ] Soft tissue mass
   - [ ] Spinal cord compression
   - [ ] Other

5. What is the patient’s ECOG performance status? Check one.
   - [ ] 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.

5a. Is the performance status expected to improve as a result of this treatment? [ ] Yes [ ] No

6. Is the area to be treated abutting, overlapping or within a previously irradiated area? [ ] Yes [ ] No

7. Note any additional information in the space below.

Completed by: ____________________________ Date: ____________________________