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.

<table>
<thead>
<tr>
<th>Patient name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please provide the radiation therapy treatment start date (MM/DD/CCYY):</td>
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<tr>
<td><strong><strong><strong>/</strong></strong></strong>/______</td>
</tr>
</tbody>
</table>

1. Is the treatment being directed to the primary site (breast)?
   - If no, please submit a request for the metastatic site being treated.
   - □ Yes □ No

2. Does the patient have distant metastatic disease (M1 stage)?
   - □ Yes □ No

3. Please check the box indicating the intent of the treatment (select one only).
   - □ Adjuvant/prevention of locoregional recurrence
   - □ Treatment of clinically apparent tumor that is asymptomatic
   - □ Palliation of clinically apparent tumor at chest wall/breast

   If palliative go directly to question #7.

4. Please check box to indicate the T-stage (pathologic T-stage if patient has had surgery).
   - □ T1 □ Ductal carcinoma in situ (DCIS)
   - □ T2
   - □ T3
   - □ T4 □ Recurrent

5. a. Are you treating the internal mammary lymph nodes?
   - □ Yes □ No
   - b. Is the mid-tangential treatment separation greater than 25.5 cm?
     - □ Yes □ No
   - c. Is the bra cup size D or greater?
     - □ Yes □ No

6. Please select the treatment plan to be executed for the initial phase (select one only).
   - □ Whole breast
   - □ Chest wall radiotherapy
   - □ Partial breast radiotherapy

7. Is this a request for inverse planned IMRT?
   - □ Yes □ No

8. Have you considered a forward planned IMRT treatment plan for this patient?
   - □ Yes □ No

9. Note any additional information in the space below.

Completed by: ________________________________ Date: ________________________________

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