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 patient’s WHO grade?
   - □ I: Pilocytic astrocytoma
   - □ II: Low-grade oligo/astrocytoma/ependymoma
   - □ III: Anaplastic astrocytoma
   - □ IV: Glioblastoma multiform (GBM)

5. What is the patient’s ECOG performance status?
   - □ 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 housework, 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.

3. What surgery has been performed?
   - □ Biopsy only
   - □ Subtotal resection
   - □ Gross total resection

4. Is the area to be treated abutting, overlapping or within a previously irradiated area? □ Yes □ No

5. What is the intent of treatment? □ Palliative □ Curative

6. Note any additional information in the space below.

Completed by: ____________________________ Date: ____________________________