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>
</tr>
</tbody>
</table>

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

2. What is the intent of the treatment? Check one box and complete its corresponding section.
   - Post-operative
     - Select operation type:
       - Radical hysterectomy
       - Simple hysterectomy
   - Surgical findings:
     - Negative node with high risk factors:
       - Large primary tumor (larger than 4 cm)?
       - Deep stromal invasion?
       - Lymphovascular invasion?
     - Positive pelvic nodes?
     - Positive surgical margin?
     - Positive parametrium?
     - Positive para-aortic nodes?
   - Definitive
     - What is the patient’s initial FIGO (International Federation of Gynecology and Obstetrics) stage?
       - Stage I
       - Stage IA
       - Stage IA1
       - Stage IA2
       - Stage IB
       - Stage IB1
       - Stage IB2
       - Stage II
       - Stage II A
       - Stage II A1
       - Stage II A2
       - Stage II B
       - Stage III
       - Stage III A
       - Stage III B
       - Stage IVA
       - Stage IV B
       - Locoregional recurrence

3. Will the para-aortic nodes be treated?
   - Yes
   - No

4. Is gross adenopathy present?
   - Yes
   - No

5. Have you considered a 3-dimensional treatment plan for this patient?
   - 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: _______________________________