# Intensity Modulated Radiation Therapy Request for Treating Colorectal Cancer

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. Fax the form to the fax number listed on the corresponding IMRT prior authorization request cover sheet. Thank you.

<table>
<thead>
<tr>
<th>Patient name:</th>
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| Please provide the radiation therapy treatment start date (MM/DD/CCYY): | _____ / _____ / _____ |

| 1. Is this treatment being directed to the primary site?  
*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. What is the circumstance of radiation?  
☐ Adjuvant radiation (post-operative)  
☐ Neo-adjuvant (pre-operative)  
☐ Initial primary treatment/definitive (no surgery planned)  
☐ Local recurrence/persistence  
☐ Retreatment of an area that is immediately adjacent to or has been previously irradiated  
☐ Palliation | |

| 4. What is the T stage?  
☐ T0  
☐ T1  
☐ T2  
☐ T3  
☐ T4a  
☐ T4b | |

| 5. What is the nodal status? | ☐ Negative ☐ Positive |

| 6. What is the margin status? | ☐ Negative ☐ Positive |

| 7. What is the intended dose of radiation? | ___________ Gy |

| 8. Note any additional information in the space below. | |

Completed by: ________________________________________                          Date: ______________________________________

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