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>
</tr>
</thead>
</table>

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

1. Will the treatment be directed to the primary site (stomach)?
   - [ ] Yes
   - [x] No

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

3. Does the patient require palliative treatment to the abdomen?
   - [ ] Yes
   - [ ] No

4. What is the timing of the treatment?
   - [ ] Adjuvant radiation following surgery
   - [ ] Neoadjuvant radiation preceding surgery
   - [ ] Initial primary treatment with no surgery planned

5. I [ ] HAVE [ ] HAVE NOT generated a best-effort 3-D plan for comparison.

6. What is the intended radiation total dose?
   - ________ Gy

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

8. Note any additional information in the space below.

---

Completed by: ________________________________________                          Date: ______________________________________