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):

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1. What is the site of the primary cancer?

2. 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 house work, 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.

2a. If the ECOG status is due to the cancer, is the status expected to improve with radiation therapy treatment?  

   - [ ] Yes  
   - [ ] No

3. Does the patient have distant metastatic disease? *(If the diagnosis is brain metastases or bone metastases, please stop and use the appropriate worksheet for those cancer types.)*

   - [ ] Yes  
   - [ ] No

4. What is the intent of the treatment?

   - [ ] Initial primary treatment
   - [ ] Pre-operative radiation
   - [ ] Palliation at primary site
   - [ ] Other (explain): ________________________________

   - [ ] Post-operation radiation
   - [ ] Isolated local recurrence at primary or adjacent site
   - [ ] Palliation of metastatic site (specify site):

5. For definitive, pre-operative or post-operative treatment only. For others types, skip to question # 6.

5a. What is the clinical stage?

   - [ ] T1  
   - [ ] T2  
   - [ ] T3  
   - [ ] T4  
   - [ ] Tx

5b. Nodes:

   - [ ] N0  
   - [ ] N1  
   - [ ] N2  
   - [ ] N3  
   - [ ] NX

6. Has this area received radiation before?  

   - [ ] Yes  
   - [ ] No

7. Have you considered using a 3-D conformal treatment plan?  

   - [ ] Yes  
   - [ ] No

8. Note any additional information in the space below.

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Completed by: ________________________________ Date: ________________________________

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