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>
<tr>
<td><strong><strong><strong>/</strong></strong></strong>/______</td>
</tr>
</tbody>
</table>

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

2. What is the pathology?
   - [ ] Endometrioid
   - [ ] Papillary serous
   - [ ] Sarcoma
   - [ ] Other

3. What is the grade?
   - [ ] G1
   - [ ] G2
   - [ ] G3
   - [ ] N/A

4. What is the patient’s initial FIGO (International Federation of Gynecology and Obstetrics) stage?
   - [ ] Stage I
   - [ ] Stage IA
   - [ ] Stage IB
   - [ ] Stage IC
   - [ ] Stage II
   - [ ] Stage III
   - [ ] Stage IIIA
   - [ ] Stage IIIIB
   - [ ] Stage IIIIC
   - [ ] Stage IIIIC1
   - [ ] Stage IIIIC2
   - [ ] Stage IVA
   - [ ] Stage IVB

5. What is the intent of the treatment?
   - [ ] Post-hysterectomy
     - [ ] Positive pelvic nodes
     - [ ] Positive surgical margin
     - [ ] Positive parametrium
     - [ ] Positive para-aortic nodes
   - [ ] Definitive (no hysterectomy)
   - [ ] Locoregional recurrence
   - [ ] Palliative

6. Will the para-aortic nodes be treated?
   - [ ] Yes
   - [ ] No

7. Is gross adenopathy present?
   - [ ] Yes
   - [ ] No

8. Have you considered a 3-dimensional treatment plan for this patient?
   - [ ] Yes
   - [ ] No

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

10. Note any additional information in the space below.

Completed by: ___________________________ Date: ___________________________