Prior Authorization for Therapeutic Radiation Procedures Including Intensity Modulation Radiation Treatment (IMRT), Stereotactic Radio Surgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)

This worksheet is a tool to help you identify and collect the clinical information required to support a prior authorization request for Medicare Advantage members. After the clinician completes the clinical information, please go to UHCprovider.com > Prior Authorization and Notification > Oncology > Medicare Advantage Therapeutic Radiation to submit the prior authorization request. Submitting the clinical information from this worksheet alone won’t automatically result in prior authorization approval. If you have questions about prior authorization submissions or need to request an expedited review, please call UnitedHealthcare Clinical Requests at 866-889-8054.

**Member name:**

Please provide the radiation therapy treatment start date (MM/DD/YYYY): ____ / ____ / ____

1. What is the site of the primary cancer? (select all that apply)
   - Bladder
   - Colorectal
   - Liver
   - Pancreas
   - Breast
   - Head/Neck
   - Lung
   - Prostate
   - Other: ______________
   - Cervix/Endometrium
   - Kidney
   - Melanoma
   - Sarcoma

2. What is the member’s ECOG performance status? (select one only)
   - 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 percent of waking hours.
   - 3 - Capable of only limited self-care, confined to bed or chair more than 50 percent of waking hours.
   - 4 - Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.

3. What is the intent/timing of the treatment? Select all that apply.
   - New metastatic disease
   - Oligo-metastatic disease
   - Liver-only active or residual disease after chemotherapy (consolidation)
   - Palliation of symptoms
   - Other: ____________________________

4. How many liver metastases are present?
   - 1 to 3
   - 4 or more
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<td>5.</td>
<td>Does the member currently have other sites of metastatic disease?</td>
<td>□ Yes □ No</td>
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<tr>
<td>5a.</td>
<td>Has the member ever had other sites of distant metastases?</td>
<td>□ Yes □ No</td>
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<td>6.</td>
<td>Has the member had a staging reevaluation in the last 90 days?</td>
<td>□ Yes □ No</td>
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<td>7.</td>
<td>Does the member have other sites (including the primary site) that are suspicious for active or residual disease on the most recent PET/CT or CT scans?</td>
<td>□ Yes □ No</td>
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<td>8.</td>
<td>Is the member a candidate for RFA, surgery, or other local therapy?</td>
<td>□ Yes □ No</td>
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<td>9.</td>
<td>What is the treatment technique being requested? (select one only)</td>
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<td></td>
<td>IMRT</td>
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<td>SBRT</td>
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<td>10.</td>
<td>If the requested treatment is SBRT, can all of the disease in the liver be included and treated in one course of SBRT treatment?</td>
<td>□ Yes □ No</td>
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<td>11.</td>
<td>Has the member had chemotherapy or other systemic therapy in the last six months?</td>
<td>□ Yes □ No</td>
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<td>12.</td>
<td>Please note any additional information below.</td>
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