Physician Worksheet for Other Cancer Types Medica
re Advantage Prior Authorization Request

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 primary site? __________________________________________________

Do not proceed if treatment is being directed to a metastatic site, such as bone, brain, liver, or lung.
Instead, complete the appropriate worksheet for the metastatic site.

2. Will the treatment be directed to the primary site? □ Yes □ No

3. Does the member have distant metastatic disease? □ Yes □ No

4. What is the intent/timing of the treatment?

□ Initial primary treatment □ Isolated local recurrence at primary or adjacent site
□ Pre-operative radiation □ Palliation
□ Post-operation radiation □ Other: __________________________________________

5. What is the intended total radiation dose?

□ Less than 30.1 Gy □ 40.1 Gy to 50 Gy
□ 30.1 Gy to 40 Gy □ Greater than 50 Gy

6. Is the area to be treated abutting, within, or overlapping an area that has
been previously treated with radiation therapy? □ Yes □ No

7. What is the treatment technique being requested? (select one only)

□ IMRT □ SRS/SBRT boost (up to 5 treatment fractions)
□ SRS/SBRT (up to 5 treatment fractions) □ Other: __________________________________

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8. Did you consider 3D, including Tomo3D, for the member? □ Yes □ No

9. Please note any additional information in the space below, including whether other means of management have failed.