UnitedHealthcare

Physician Worksheet for
Primary CNS Neoplasm
Medicare 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 UnitedHealthcare 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; additional clinical information may be requested during the clinical review process. If you have questions about your submission or need to request an expedited review, please call 866-889-8054.

Patient name:			**DOB:** ______ /______ /______
What is the radiation therapy treatment start date (mm/dd/yyyy)?			______ /______ /______
1.	What is the patient's WHO grade or diagnosis?		
	WHO grade	☐ I: Pilocytic astrocytoma ☐ II: Low grade oligo/ astrocytoma/ependymoma ☐ III: Anaplastic astrocytoma ☐ IV: Glioblastoma multiform (GBM)	
	Diagnosis	☐ Primary spinal tumor ☐ Ependymoma ☐ Recurrent primary CNS malignant tumor previously irradiated ☐ Adult medulloblastoma ☐ Supratentorial PNET (primitive neuroectodermal tumor) ☐ Benign: Meningioma, Schwannoma, Pituitary Adenoma ☐ Other: ________________________________	
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.

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3.	What resection has been performed?
	☐ Biopsy only ☐ Subtotal resection ☐ Gross total resection ☐ Other: _______________
4.	What technique will be used to deliver the radiation therapy?
	☐ Intensity modulated radiation therapy (IMRT) ☐ Stereotactic body radiation therapy (SBRT) ☐ Stereotactic radiosurgery (SRS)
5.	Note any additional information in the space below: