**Physician Worksheet for Primary Lung Cancer**  
**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 Medicare Advantage members. After the clinician completes the clinical information, please go to [UHCprovider.com](http://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**.

<table>
<thead>
<tr>
<th>Member name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please provide the radiation therapy treatment start date (MM/DD/YYYY):</td>
</tr>
</tbody>
</table>

1. **What type of lung cancer does the member have? (select one)**  
   - [ ] Small cell lung cancer  
   - [ ] Non-small cell lung cancer

2. **Will the treatment be directed to the primary site?**  
   - [ ] Yes  
   - [ ] No

   **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.**

3. **Does the member have distant metastatic disease?**  
   - [ ] Yes  
   - [ ] No

4. **Is the treatment intent palliation?**  
   - [ ] Yes  
   - [ ] No

5. **Is the staging T1/T2, N0, M0?**  
   - [ ] Yes  
   - [ ] No

6. **Is bilateral hilar and/or mediastinal adenopathy present?**  
   - [ ] Yes  
   - [ ] No

7. **Is the tumor located immediately adjacent to the spine, heart, or brachial plexus?**  
   - [ ] Yes  
   - [ ] No

8. **Is the area to be treated abutting, within, or overlapping an area that has been previously treated with radiation therapy?**  
   - [ ] Yes  
   - [ ] No

9. **Did you consider 3D, including Tomo3D, for the member?**  
   - [ ] Yes  
   - [ ] No

*Continued on next page*
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<table>
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<tr>
<th>10.</th>
<th>What is the treatment technique being requested? (select one only)</th>
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<tbody>
<tr>
<td></td>
<td>□ IMRT □ SBRT □ SBRT boost □ Other: _______________________</td>
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<th>11.</th>
<th>Please note any additional information below.</th>
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