



Radiation Therapy Other Cancer Checklist

Evolent has provided this checklist to help you in gathering the information needed to request a medical necessity review. Please complete this form and include any applicable clinical documentation (i.e., comparison plan, radiation therapy consultation, imaging results etc.) prior to submitting the case on [RadMD.com](https://www.radmd.com). As an alternative, you may also contact our Evolent Call Center.

Other Cancer checklist used for but not limited to diagnosis of: Bladder, Esophagus, Hepatocellular (HCC) Liver Primary, Leukemia, Multiple Myeloma (Plasmacytoma, Active or Smoldering), Mycosis Fungoides, Sarcoma, Thymoma, Thyroid, Trachea, Urethra Cancer, Vaginal, and Vulvar Cancer.

Please note new case requests **may not** be started by fax.

General Information			
Patient Name:			
Date of Birth:			
Health Plan and Member ID:			
Treatment Planning Start Date (i.e., Initial Simulation):			
Treatment Start Date:			
Clinical Information			
ICD-10 Code(s):			
What is the treatment site? Each treatment site requires a separate authorization.			
What is Treatment Intent? Curative/ Palliative			
What is the treatment prescription dose for the course of treatment?			
What is the radiation therapy treatment start date?			
Does the member have distant metastases (stage VI or M1) (i.e., disease spread to bone, liver, lung, brain)?			
Will all radiation treatment be done at the same facility? YES <input type="checkbox"/> NO <input type="checkbox"/>			
History of prior radiation therapy? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>If yes, provide details of prior site & total dose along with completion date:</i>			
What is the DOSE that will be used for each phase of treatment?			
Phase 1			
Phase 2			
Phase 3			
PLEASE INDICATE THE NUMBER OF FRACTIONS FOR EACH PHASE BELOW			
Phase 1	Phase 2 (Boost)	Phase 3	Treatment
			Superficial / Orthovoltage
			2D Radiation Therapy
			3D Radiation Therapy

			Electron Beam Therapy
			Intensity Modulated Radiation Therapy (IMRT)
			Proton Beam Therapy
			Stereotactic Radiosurgery & Stereotactic Radiation Therapy (SRS/SRT)
			Stereotactic Body Radiation Therapy (SBRT)
			Gamma Knife YES <input type="checkbox"/> NO <input type="checkbox"/>
			IORT Machine Name:
			LDR Brachytherapy
			HDR Brachytherapy

Plan Type: **IMRT:** **3D:** Plan Type for SBRT/SRS/SRT and Proton Beam Therapy

Site Specific Questions for Other Cancer:

Diagnosis:

Original Tumor resected: Yes No

Treatment Intent: Curative or Palliative

T Stage	N Stage
TX	NX
T1	N0
T2	N1
T3	N2
T4	N3
M Stage (M1)	
Location of Distant Metastasis:	

Will Selective Internal Radiation Therapy (SIRT) be used?

SIRT CPT Code: 77778 C2616

Will Total Skin Electron Beam therapy (TSEBT) be used?

Number of ports/angles/fields

Phase 1

Phase 2

Phase 3

Type of Imaging: Port Films IGRT IGRT Frequency:

Will concurrent (simultaneous) chemotherapy be administered during this course of treatment?

YES NO **Chemotherapy name:**

Chemo dates:

CPT Code 77370 Special Physics
CPT Code 77470 Special Treatment
CPT Code 77331 Special Dosimetry

Rationale (Reason)
Rationale (Reason)
Rationale (Reason)

Additional comments or details:

Please be ready to submit any results of imaging (ultrasounds, x-rays, MRIs, PET Scans, CTs, DVH's) from the past 3 months and radiation therapy prescription plans in addition to the clinical treatment plan. This will assist in the review process. Failure to provide all relevant documentation may cause a delay.