ONCOLOGY ANALYTICS

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Radiotherapy (XRT) Prior Authorization Request Form

REQUEST DATE: _____ (MM/DD/YYYY) **TREATMENT START DATE:** _____ (MM/DD/YYYY) ☐ **Standard** ☐ **Expedited**

I. MEMBER INFORMATION

First:	Last:	DOB:	☐ Male ☐ Female
Insurance:	Line of Business (e.g., Medicare):	Member ID:	
Diagnosis:	ICD-10:	Stage (0-4):	

II. REQUIRED TREATMENT INFORMATION ☐ New ☐ Retrospective ☐ Re-authorization

	1st XRT Technique, e.g., IMRT	2nd XRT Technique, If Applicable, e.g., Brachy Boost	3rd XRT Technique, If Applicable
Radiotherapy Technique			
Number of Fractions, e.g., 44			

If the radiotherapy is medically necessary, then Oncology Analytics will indicate to the health plan which billing codes and quantities are appropriate based on the current ASTRO Radiation Oncology Coding Resource Digital eBook.

III. OPTIONAL SUPPORTING INFORMATION

a. Total dose (Gy), e.g., 79.20 Gy?	1st Technique: _____ Gy; 2nd: _____ Gy; 3rd: ____ Gy
b. Treatment site, e.g., prostate?	_____
c. Intent of therapy?	☐ Curative ☐ Palliative ☐ Unknown
d. Will chemotherapy be given concurrently with radiotherapy?	☐ YES ☐ NO ☐ Unknown
e. Has the planned treatment site been previously irradiated?	☐ YES ☐ NO ☐ Unknown
f. Histology (e.g., adenocarcinoma)	
g. TNM (Tumor Size, Nodal Status, Distant Metastasis)	T: _____ N: _____ M: _____
h. ECOG performance status (PS: 0, 1, 2, 3, 4 or unknown)	ECOG PS: _____ ☐ Unknown
i. Timing of radiotherapy relative to surgery	☐ Pre-operative ☐ Radiotherapy alone ☐ Intra-operative ☐ Post-operative

IV. PROVIDER AND PLACE OF TREATMENT INFORMATION

Ordering Provider:	NPI #:	TIN #:
	Phone:	Fax:
Treating Provider: (if different)	NPI #:	TIN #:
Place of Treatment: (if different)	NPI #:	TIN #:
Requestor's Name:	Phone:	Fax:

SUBMIT XRT CONSULTATION NOTE, XRT PRESCRIPTION, PATHOLOGY AND RECENT IMAGING RESULTS WITH REQUEST.