OncoHealth

261 N. University Drive, Suite 710, Plantation, FL 33324
Phone: 888.916.2616 • Fax: 800.264.6128
www.oncohealth.us

Need to submit a request quickly? Visit our web portal at oneum.oncohealth.us

Radiotherapy (XRT) Prior Authorization Request Form

REQUEST DATE: _____ **TREATMENT START DATE: _____**

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

☐ **Standard**

☐ **Urgent** - Mark as **Urgent**, if the request meets one of the definition/level of service listed below

- ☐ Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment; or
- ☐ Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological function; or
- ☐ In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
- ☐ Based on this definition, I hereby submit this authorization as an urgent request

MEMBER INFORMATION

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

I. REQUIRED TREATMENT INFORMATION ☐ New ☐ 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 OncoHealth will indicate to the health plan which billing codes and quantities are appropriate based on the current ASTRO Radiation Oncology Coding Resource Digital eBook.

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

II. PROVIDER AND PLACE OF TREATMENT INFORMATION

Ordering Provider:	NPI #:	TIN #:
	Phone:	Fax:
Address:	City:	State: Zip:

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Treating Provider: (if different)	NPI #:	TIN #:
Place of Treatment: (if different)	NPI #:	TIN #:
Office Contact Name:	Phone:	Fax:

Is the patient currently being treated with the requested regimen(s)?	☐ Yes ☐ No ☐ Unknown
Has this patient been receiving active care from this treating/servicing provider?	☐ Yes ☐ No ☐ Unknown
Is this the only available treating/servicing provider within a reasonable distance that can provide this treatment/service for the patient?	☐ Yes ☐ No ☐ Unknown
Does this patient have a referral from the Health Plan to see this treating/servicing provider?	☐ Yes ☐ No ☐ Unknown
Has the patient been receiving radiation therapy from the treating/servicing provider?	☐ Yes ☐ No ☐ Unknown
Is the treating/servicing provider in-network?	☐ Yes ☐ No ☐ Unknown

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