PRIOR AUTHORIZATION for RADIATION THERAPY

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

Date Requested:		Rendering Provider Name:
Rendering Provider NPI #:	**Rendering Provider Tax ID #:**	**Rendering Provider Address:**

Rendering Provider Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*	Requested Date(s) of Service:	Place of Service: *Please check.*
☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	From: To:	☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Facility Name:	Facility NPI #:	Facility Tax ID #:

Facility Address:	Facility Phone: ( )	Facility Facsimile: ( )

Primary Diagnosis/ICD-10 Code:	Secondary Diagnosis/ICD-10 Code:

A. Stage of Disease (T, N, M):	B. Metastatic Site (s): ☐ N/A	C. Karnofsky/ECOG Score:

D. Indication for Radiation Therapy: *Please check.*

☐ Adjuvant ☐ Chemoradiation ☐ Consolidative ☐ Curative ☐ Neoadjuvant ☐ Palliative ☐ Other *(please specify)*: _____

E. Type of Radiation Modality/Technique Being Requested: *Please check all that apply.*

1. ☐ Accelerated
2. ☐ Accelerated-Fractionated
3. ☐ Accelerated Partial Breast Irradiation/APBI
4. ☐ Accelerated Whole Breast Irradiation/AWBI
5. ☐ Boost
6. ☐ Conformal/3D (3D-CRT)
7. ☐ Conventional/2D (2DRT)
8. ☐ External Beam/EBRT
9. ☐ High Dose/HDR Brachytherapy
10. ☐ Hyperfractionated (or Superfractionated)
11. ☐ Hypofractionated
12. ☐ Image Guided/IGRT
13. ☐ Intensity Modulated/IMRT
14. ☐ Internal (Brachytherapy)
15. ☐ Interstitial Brachytherapy
16. ☐ Intracavitary Brachytherapy
17. ☐ Intraoperative/IORT
18. ☐ Low Dose/LDR Brachytherapy
19. ☐ Neutron Beam/NBT
20. ☐ Proton Beam/PBRT
21. ☐ Stereotactic Body/SBRT
22. ☐ Stereotactic Radiosurgery/SRS
23. ☐ Systemic (e.g., Radioactive Iodine)
24. ☐ Tomotherapy
25. ☐ Whole Brain/WBRT
26. ☐ Whole Breast/WBRT
27. ☐ Selective Internal/SIRT
28. ☐ Superficial Radiation Therapy/SXRT
29. ☐ Transarterial Radioembolization/TARE
30. ☐ Other (*please specify*): _____

F. Primary Treatment Site:	G. Secondary Treatment Site:	H. Boost Treatment Site:

I. Number of Fractions Anticipated:	J. Daily Fraction Dose (cGy):	K. Treatment Schedule:	L. Total Dose (cGy):

M. Radiation Service (s) Requested: *Please list all requested services/CPT-HCPCS codes regardless of pre-authorization requirement.*

Treatment Planning CPT/HCPCS code (s): _____

Simulation CPT/HCPCS code (s): _____

Dosimetry CPT/HCPCS code (s): _____

Treatment Device CPT/HCPCS code (s): _____

Treatment Delivery CPT/HCPCS code (s): _____

Treatment Management CPT/HCPCS code (s): _____

Other Procedure/Service: _____ CPT/HCPCS code: _____

Other Procedure/Service: _____ CPT/HCPCS code: _____

Additional Comments:

Please fax completed form and medical records to 801-366-7449.