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:		Service Provider Name:
Service Provider NPI #:	Service Provider Tax ID #:	Service Provider Address:
Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	**Requested Date (s) of Service:**	**Place of Service:** *Please check.* ☐ 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 (e.g., Linear Accelerator/LINAC, Cyberknife®, Gamma Knife®)
23. ☐ Systemic (e.g., Radioactive Iodine)
24. ☐ Tomotherapy
25. ☐ Whole Brain/WBRT
26. ☐ Whole Breast/WBRT
27. ☐ Selective Internal/SIRT or Transarterial Radioembolization/TARE (e.g. Sir-Spheres®, TheraSpheres®)
28. ☐ Superficial Radiation Therapy (SXRT)
29. ☐ 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 Service (s): ______________________ CPT/HCPCS code (s): ______________________

Simulation Service (s): ______________________ CPT/HCPCS code (s): ______________________

Dosimetry Service (s): ______________________ CPT/HCPCS code (s): ______________________

Treatment Device (s): ______________________ CPT/HCPCS code (s): ______________________

Treatment Delivery Service (s): ______________________ CPT/HCPCS code (s): ______________________

Treatment Management Service (s): ______________________ 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.