

Review Request for Brachytherapy for Oncologic Indications

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Policy Last Review Date: 05/21/09	Policy Effective Date: 07/15/09	Provider Tool Effective Date: 08/31/09
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Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:
Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:
Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:
Facility Name:	Facility ID Number:
Facility Address:	
Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Service Requested (CPT if known):	
Diagnosis (ICD-9) if known:	

Please check all that apply to the member:

- Request is for Breast brachytherapy as an adjunctive “boost” to the tumor bed for a member who has received whole breast radiation therapy after prior breast conserving surgery (i.e., lumpectomy).
- Request is for Breast brachytherapy as a technique of partial breast irradiation (e.g., multicatheter interstitial; Mammosite RTS device, Proxima Therapeutics, Alpharetta, GA) as an alternative to whole breast irradiation (check all that apply):
 - Tumor removed with breast conserving surgery (i.e., lumpectomy) with resected margins free of tumor;
 - Histologically confirmed ductal carcinoma in situ or invasive adenocarcinoma of the breast;
 - Stage 0, I, or II disease (Stage II tumors must be less than or equal to 3cm in diameter);
 - No more than three positive axillary nodes
 - Other: _____

- Request is for Ocular brachytherapy for choroidal melanoma (check all that apply):
- Unilateral choroidal melanoma has been confirmed
 - Apical height of the tumor is 2.5 to 10.0mm
 - Maximum basal tumor diameter of 18.0mm or less
 - Other: _____
- Request is for Endobrachial brachytherapy (check all that apply):
- Primary tumor cannot be excised
 - Primary tumor cannot be treated by external beam radiation therapy (EBRT)
 - As a palliative treatment for obstructing primary or metastatic endobronchial tumors
 - As "boost" for EBRT
 - Other: _____
- Request is for Esophageal brachytherapy (check all that apply):
- Unresectable tumor(s)
 - Palliative treatment for obstructing tumors
 - Other: _____
- Request is for brachytherapy for the treatment of head and neck cancer(s) (check all that apply)
- | | | | |
|---------------------------------------|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Lip | <input type="checkbox"/> Tongue | <input type="checkbox"/> Floor of mouth | <input type="checkbox"/> Tonsil |
| <input type="checkbox"/> Pharynx | <input type="checkbox"/> Nasopharynx | <input type="checkbox"/> Sinuses | <input type="checkbox"/> Neck cancers |
| <input type="checkbox"/> Other: _____ | | | |
- Member has Prostate cancer (check all that apply):
- Request is for permanent radioactive seed implantation for prostate cancer with or without EBRT
 - Request is for high dose rate (HDR) brachytherapy, a temporary seed implantation, for locally advanced prostate cancer (T1C, PSA \geq 10, T2/T3)
 - Other: _____
- Request is for brachytherapy as part of combination therapy in a member with soft tissue sarcoma that (check all that apply):
- Has positive margins
 - Has margins < 5mm
 - Other: _____
- Request is for brachytherapy in member diagnosed with uterine, cervical, endometrial or vulvar/vaginal cancer
- Request is for high dose rate electronic brachytherapy
- Other: _____

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: _____
- By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name and Title of Provider or Provider Representative
Completing Form (Please Print)*

Date

* The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.