

Review Request for
**Transcatheter Arterial Chemoembolization (TACE)
 and Transcatheter Arterial Embolization (TAE)**



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

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

Provider Data Collection Tool Based on Medical Policy RAD.00011

Policy Last Review Date: 11/19/2 Policy Effective Date: 01/13/2 Provider Tool Effective Date: 05/26/2

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
Service Requested (CPT if known):	<input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Diagnosis (ICD-9) if known:	

Please check all that apply to the member:

- Request is for Transcatheter arterial chemoembolization (TACE)
- Request is for Transcatheter arterial embolization (TAE)
- Request is for TACE utilizing chemotherapy-loaded microspheres (i.e. drug-loaded microspheres, drug-eluting beads)
- Other: _____

- Request is for palliative treatment of primary hepatic or metastatic tumors
 - Member has neuroendocrine tumor (carcinoid tumors, pancreatic islet cell tumors, parathyroid, pituitary angiomas)
 - Systemic therapy has failed to control symptoms such as carcinoid syndrome (debilitating flushing, wheezing, and diarrhea)

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- Member has symptoms from non-carcinoid neuroendocrine tumors (hypoglycemia, severe diabetes, Zollinger-Ellison Syndrome) with hepatic metastasis
 - Member has symptoms due to hepatic tumor bulk (e.g., pain)
 - Request is for treatment of liver-only metastasis from uveal (ocular) melanoma
 - Other: _____
-
- Request is for treatment of Hepatocellular Carcinoma or Bridge to Liver Transplantation
 - Treatment is for primary treatment for a surgically unresectable primary hepatocellular carcinoma
 - Treatment is for bridge to liver transplantation
 - Member has preserved liver function defined as Childs-Turcotte-Pugh Class A or B
 - Member has 3 or fewer encapsulated nodules and nodules are less than 5 cm in diameter
 - Member has no evidence of extra-hepatic metastases
 - Member has no evidence of severe renal function impairment
 - Member has no evidence of portal vein occlusion
 - Other: _____

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: _____

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 and Attestation (Please Print)*

Date

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