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Medicare Intensity Modulated Radiation Therapy Required Documentation Form

For Medicare Advantage Members Only:

Fax: 1-855-232-0085, or submit via the

[Electronic Authorization Workflow](#)

Mail to: PO Box 1106, Lewiston, ID 83501-1106

Intensity Modulated Radiotherapy (IMRT) requires prior authorization. To streamline the prior authorization process, several indications do not require a dose-volume histogram analysis (see Table 1 and 2).

If required items are not provided, it could impact our review and decision outcome. **Note: Providers are responsible for submitting valid ICD-10 codes, coded to the highest level of specificity. Many “unspecified” ICD-10 codes may not be eligible for coverage.**

Table 1: No dose/volume histogram analysis needed

Policy criteria are met = No dose/volume histogram analysis required
<ul style="list-style-type: none">Intensity Modulated Radiotherapy (IMRT) of the Central Nervous System (CNS), Head, Neck, and Thyroid, Medicine, Policy No. 164Intensity Modulated Radiotherapy (IMRT) of the Thorax, Abdomen, Pelvis, and Extremities, Medicine, Policy No. 165Intensity Modulated Radiotherapy (IMRT) for Breast Cancer, Medicine, Policy No. 166 only for the following:<ul style="list-style-type: none">Accelerated partial breast irradiation (APBI)Prior radiation to the planned target volume
<i>It is sufficient to provide physical/chart notes, relevant imaging, tumor type, and tumor location for review. The policies listed above may receive auto-approval in the electronic authorization tool when policy criteria are met.</i>

Table 2: Dose/volume histogram analysis (in color) needed

Submit dose/volume histogram in color and summary analysis (see Section 4)
<ul style="list-style-type: none">Policy criteria from Table 1 above are not metIntensity Modulated Radiotherapy (IMRT) for Breast Cancer, Medicine, Policy No. 166Intensity Modulated Radiotherapy (IMRT) for Tumors in Close Proximity to Organs at Risk, Medicine, Policy No. 167
<i>For cases where IMRT is medically necessary to meet published dose/volume constraints for organs at-risk (see Medical Policy MED167) the table below (Section 4) is intended to aid the provider in submitting the prior authorization.</i>

The sections below will help inform the prior authorization request and the clinical documentation needed. If any of these items are not provided, it could impact our review and decision outcome.

Instructions: This form should be filled out by the provider requesting IMRT services. Please complete all applicable fields and include with your IMRT prior authorization request.

SECTION 1 – PATIENT INFORMATION

Patient Name (Last):	(First):	(MI):	Date of Birth	Patient's Member ID Number:	Group Number:
			MM/DD/YYYY		

SECTION 2 – PROVIDER INFORMATION

Provider Name:	Phone Number:	Confidential Voice Mail:
		<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 3 – REQUEST INFORMATION

Select the relevant indication below:

Thorax, Abdomen, Pelvis, and Extremities	CNS, Head, Neck, and Thyroid	Breast Cancer
<u>No dose-volume histogram analysis needed for the following indications (do not complete Section 4 below):</u>		
<input type="checkbox"/> Prior radiation to the planned target volume; or <input type="checkbox"/> Curative treatment for one of the following indications: <input type="checkbox"/> Esophageal and gastroesophageal junction cancer <input type="checkbox"/> Lung cancer including non-small cell or small cell <input type="checkbox"/> Pleural mesothelioma <input type="checkbox"/> Thymic carcinoma <input type="checkbox"/> Thymoma <input type="checkbox"/> Treatment of soft tissue sarcoma; see Medical Policy Criteria <input type="checkbox"/> Primary, adjuvant, or salvage treatment of pancreatic cancer <input type="checkbox"/> Treatment of cervical cancer post-hysterectomy or unresectable cervical cancer <input type="checkbox"/> Treatment of vulvar or vaginal cancer <input type="checkbox"/> Primary treatment of local (clinical or pathological T1, T2, N0, M0) or locally advanced (clinical or pathological T3, T4, N0, N1, M0) prostate cancer; or <input type="checkbox"/> Low metastatic burden prostate cancer (5 or fewer bone metastases, no lymph node involvement outside the pelvic lymph nodes, and no visceral metastasis) when planned target volume includes all oligometastatic foci; or <input type="checkbox"/> Adjuvant or salvage prostate cancer post radical prostatectomy (see additional policy criteria); or <input type="checkbox"/> Cancer of the anus/anal canal.	<input type="checkbox"/> Prior radiation to the planned target volume; or <input type="checkbox"/> Definitive radiotherapy for pediatric (less than 21 years of age) central nervous system (CNS) tumor; or <input type="checkbox"/> Hippocampal-avoiding treatment for brain metastases and both of the following: <input type="checkbox"/> Metastases are outside a 5mm margin around the hippocampi, and <input type="checkbox"/> Clinical documentation that expected survival is >4 months <input type="checkbox"/> Primary or recurrent cancer arising from the oral cavity and lip, larynx, hypopharynx, oropharynx, nasopharynx, paranasal sinuses nasal cavity, salivary glands, and soft tissue sarcomas, unusual histologies or occult primaries in the head and neck region; or <input type="checkbox"/> Lymphomas in the head and neck region (excluding follicular and malt and marginal zone lymphomas); or <input type="checkbox"/> Thyroid cancer for any of the following: <input type="checkbox"/> Locoregional recurrence; or <input type="checkbox"/> Anaplastic thyroid cancer; or <input type="checkbox"/> Node positive or node-recurrent; or <input type="checkbox"/> There is documentation of muscle invasion.	<input type="checkbox"/> Prior radiation to the planned target volume <input type="checkbox"/> Accelerated partial breast irradiation (APBI) <i>For all other indications, please complete Section 4 below.</i>

☐ Please complete Section 4 below when any of the policy criteria above are not met and tumor is in close proximity to organs at risk:

SECTION 4 – INTENSITY MODULATED RADIOTHERAPY DOSE-VOLUME HISTOGRAM IN COLOR AND SUMMARY ANALYSIS

Summary analysis of 3D vs IMRT planning and color dose-volume histogram are required for certain tumors in close proximity to organs at risk as indicated in Section 3 above.

Organ(s) At Risk	Dose Constraint	Source of Constraint	Result with 3D	Result with IMRT	Can constraint <i>only</i> be met with IMRT?
Example: Brachial plexus	Max <66 Gy	RTOG	58 Gy	52 Gy	No (both meet constraint)
Example: Cauda equina	Max < 16 Gy	RTOG #6301	19Gy	17 Gy	No (neither meets constraint)
Example: Brain stem	Max <54 Gy	Quantec	62 Gy	53 Gy	Yes (only IMRT meets constraint)