

PET – PET CT PRIOR AUTHORIZATION FORM

SECTION 1. MEMBER DEMOGRAPHICS					
Patient Name (First, Last):				DOB:	
Health Plan:		Member ID #:		Group #:	
SECTION 2. ORDERING PROVIDER INFORMATION					
Physician Name (First, Last):					
Primary Specialty:		NPI:		Tax ID:	
Phone #:		Fax #:		Contact Name:	
SECTION 3. FACILITY INFORMATION					
Facility Name:			Facility Tax ID:		NPI:
Address:		City:		State:	Zip:
Phone #:		Fax #:			Date of Service:
SECTION 4. EXAM REQUEST					
CPT Code(s):					
Description:					
ICD Diagnosis Code(s):					
Description:					
Date of first office visit for this condition with any provider:					
Date of most recent office visit for this condition with any provider:					
SECTION 5. COMPLETE ALL APPLICABLE INFORMATION AND CHECK THE ALL BOXES THAT APPLY					
Tumor Type :			Date of Diagnosis:		
Select Radiotracer that applies:					
<input type="checkbox"/> Standard or Routine PET or PET/CT Imaging FDG (2 fluorine 18, fluoro 2 deoxy-d-glucose)					
<input type="checkbox"/> PET Bone Scan: Sodium 18F Fluoride PET/CT					
<input type="checkbox"/> Other (describe): _____					
Does patient have a cancer diagnosis confirmed by biopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Patients Treatment History:			Reason for study:		
<input type="checkbox"/> No treatment for this type of cancer (initial staging)			<input type="checkbox"/> Initial staging		
<input type="checkbox"/> Treatment with surgery alone for this type of cancer			<input type="checkbox"/> Restaging, surveillance		
<input type="checkbox"/> Treatment other than surgery alone for this cancer			<input type="checkbox"/> Interim PET/CT for response-adapted therapy		
Currently on chemotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No			Currently on radiotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Completed chemotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No			Completed radiotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date completed: _____			Date completed: _____		
Does patient have known cancer spread to other parts of the body beyond primary tumor (metastatic disease)?: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is there suspicion of recurrence or progression based on signs, symptoms, or imaging findings?: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Prior Imaging Results and Dates:					
Additional Information:					

**Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form.
Providers may attach any additional data relevant to medical necessity criteria.**