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:

- ❑ 78814– PET BRAIN
- ❑ 78815– PET SKULL BASE TO MID THIGH
- ❑ 78816– PET WB MELANOMA SCAN

Does patient have a cancer diagnosis confirmed by biopsy? Yes No

Patient's Treatment History:	Reason for study:
❑ No treatment for this type of cancer (initial staging)	❑ Initial staging
❑ Treatment with surgery alone for this type of cancer	❑ Restaging, Surveillance
❑ Treatment other than surgery alone for this cancer	❑ Interim PET/CT for response–adapted therapy

Currently on chemotherapy: Yes No	Currently on radiotherapy: Yes No
Completed chemotherapy: Yes No	Completed radiotherapy: Yes No
Date completed: ______________________	Date completed: ____________________

Does patient have known cancer spread to other parts of the body beyond primary tumor (metastatic disease)?:

Yes No Is there suspicion of recurrence or progression based on signs, symptoms, or imaging findings?:

Additional Information:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form.
Providers attach orders and any additional data (i.e. lab, imaging, surgery, etc…) relevant to medical necessity criteria.
Be sure to provide DX to support CPT 83036– (Hemoglobin; glycosylated (A1c)

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