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:

☐ Standard or Routine PET or PET/CT Imaging FDG (2 fluorine 18, fluoro 2 deoxy-d-glucose)
☐ PET Bone Scan: Sodium 18F Fluoride PET/CT
☐ Other (describe): ______

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

Patients 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?: ☐ Yes ☐ 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.