

Mammosite Request Form

| PRESCRIBER INFORMATION | | PATIENT INFORMATION |
|------------------------------|-------------------------------------------------------|-------------------------|
| PHYSICIAN NAME | PROVIDER ID/TAX ID (if out of state must have tax ID) | PATIENT NAME |
| CONTACT PERSON/PRACTICE NAME | | PATIENT'S BCBSNC ID |
| PRACTICE PHONE | PRACTICE FAX | PATIENT'S DATE OF BIRTH |
| PRACTICE ADDRESS | CITY | STATE ZIP |

The member named above has requested use of Mammosite as part of their treatment for breast cancer.

Will electronic brachtherapy be used? If yes, then the form is complete..... Yes No

BCBSNC will provide coverage for Mammosite when the American Society of Breast Surgeons criteria (shown below) are met.

Please answer the following questions:

The patient is 45 years old or greater **and**..... Yes No

The patient has invasive ductal carcinoma or ductal carcinoma in situ (DCIS), **and** Yes No

The total tumor size (invasive and DCIS) is less than or equal to 3 cm in size, **and**..... Yes No

There are negative microscopic surgical margins of excision, **and** Yes No

The axillary lymph nodes/sentinel lymph nodes are negative..... Yes No

OR

When used as a local boost in addition to whole breast radiation therapy..... Yes No

Diagnosis Code: _____ Procedure Code: _____

Servicing Provider: _____ Phone _____ Fax _____

Effective: 08/18/10

BCBSNC does not provide coverage for Mammosite Therapy:

- When the above criteria are not met or when the benefit plan does not specifically provide coverage.

PHYSICIAN ATTESTATION: By signing below, I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Please certify the following by signing and dating below:

*Physician signature: _____ Date: _____

(*Original Physician signature required. Stamped signatures not acceptable)

For BCBSNC members, fax form to 1-800-672-6587

For NC State Health Plan members, fax form to 1-866-225-5258

An independent licensee of the Blue Cross and Blue Shield Association. ©, SM Marks of the Blue Cross and Blue Shield Association. SM1 Mark of Blue Cross and Blue Shield of North Carolina.

Your plan for better health.™ | bcbsnc.com



**BlueCross BlueShield
of North Carolina**