

Mammosite Request Form

Member Name		Member ID	
Requesting Physician		Contact Name	
Phone Number ()		Fax Number ()	

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

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

The patient is 45 years old or greater, and	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>
The patient has invasive ductal carcinoma or ductal carcinoma in situ (DCIS), and	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>
The total tumor size (invasive and DCIS) is less than or equal to 3 cm in size, and	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>
There are negative microscopic surgical margins of excision, and	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>
The axillary lymph nodes/sentinel lymph nodes are negative.	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>
OR				
When used as a local boost in addition to whole breast radiation therapy	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>

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.

By signature below, I certify that the information on this form accurately reflects the content of my medical records.

Physician Signature: _____ Date: _____

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. V521, 5/07