

# Stereotactic Radiosurgery FAX 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

**Servicing Provider:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Place of Service:** \_\_\_\_\_ **Diagnosis code:** \_\_\_\_\_ **Procedure codes:** \_\_\_\_\_

1. Stereotactic radiosurgery being requested for one of the following conditions:

- a. Arteriovenous malformation \_\_Yes \_\_No
- b. Acoustic neuroma \_\_Yes \_\_No
- c. Pituitary adenoma \_\_Yes \_\_No
- d. Non-resectable, residual, or recurrent meningioma \_\_Yes \_\_No
- e. Primary malignancy of the CNS, including high grade glioma (initial treatment or recurrence) \_\_Yes \_\_No
- f. Trigeminal neuralgia in which the patient is:
  - i. refractory to medical management \_\_Yes \_\_No
  - ii. unable to tolerate the side effects of medications \_\_Yes \_\_No

2. Is stereotactic radiosurgery being requested for brain metastases? \_\_Yes \_\_No

- a. If yes:
  - i. Does the patient have good performance status \_\_Yes \_\_No  
If yes,
  - ii. Does the patient have extracranial disease \_\_Yes \_\_No  
If yes,

**FOR INITIAL TREATMENT OF SOLITARY OR MULTIPLE BRAIN METASTASES:**

- 1. Is the extracranial disease disseminated with poor systemic treatment options? \_\_Yes \_\_No  
If no,
- 2. Is the extracranial disease either newly diagnosed, OR stable, OR reasonable systemic treatment options exist? \_\_Yes \_\_No

**FOR TREATMENT OF RECURRENT BRAIN METASTASES:**

- 3. Is the extracranial disease stable or are there reasonable systemic treatment options? \_\_Yes \_\_No

3. Is stereotactic radiosurgery being requested for one the following non-CNS conditions:

- a. Stage 1 non-small cell lung cancer? \_\_Yes \_\_No
  - i. If yes:
    - 1. The patient has no known nodal or distant disease \_\_ Agree \_\_Disagree
    - 2. The patient is not a candidate for surgical resection \_\_ Agree \_\_Disagree
- b. Spinal or vertebral body tumor (metastatic or primary) in a patient who has received prior radiation therapy? \_\_Yes \_\_No

4. Is stereotactic radiosurgery being requested for any condition not otherwise specified above? \_\_Yes \_\_No

- a. If yes, please specify below:  
 \_\_\_\_\_  
 (All other conditions are considered investigational per policy).

**Effective 5/1/11**

**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 is 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.

