**Utilization Management**
**Phone: 1-877-284-0102 Fax: 1-800-510-2162**

# PET Scan Precertification Review

Date: _____ Reference #: _____(provided after initial review)

*A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call HealthLink at 1-877-284-0102.*

**Provider Information**

Provider/Facility Name: _____

Address: _____

Phone: _____

Fax: _____

**Patient Information**

Patient Name: _____

Patient DOB: _____

ID Number: _____

Address: _____

Phone: _____

**Ordering Physician Information**

Physician Name: _____

Address: _____

Phone: _____

Fax: _____

TIN: _____

Is the doctor script on file? ☐ YES ☐ NO

**Treatment Information**

Diagnosis: _____

CPT code or codes requested: _____

_____

**Neurologic PET Scan**

Does this patient have intractable epilepsy? ☐ YES ☐ NO

Is this for identification or localization of seizure foci? ☐ YES ☐ NO

If yes, please explain: _____

_____

_____

Is this for an evaluation of dementia? ☐ YES ☐ NO

Is this patient a surgical candidate? ☐ YES ☐ NO

**Cardiac**

Is this to assess myocardial viability in a patient with severe left ventricular dysfunction? ☐ YES ☐ NO

Is this patient a candidate for surgery? ☐ YES ☐ NO

If yes, what type of surgery? _____

_____

Is this test being used to determine the presence of coronary artery disease? ☐ YES ☐ NO

Was a SPECT scan unavailable? ☐ YES ☐ NO

Was a SPECT scan inconclusive? ☐ YES ☐ NO

Does that patient have a body habitus or other condition which would or could cause a SPECT Attenuation problem and/or other technical problem? ☐ YES ☐ NO

If yes, please explain? _____

_____

Does the patient have a condition for which angiography would pose a high risk morbidity? ☐ YES ☐ NO

**Oncology**

What type of primary cancer does this patient have? _____

_____

Are there metastatic sites? ☐ YES ☐ NO

If yes, what are the sites? _____

Is the scan for initial therapy (initial staging)? ☐ YES ☐ NO

Are imaging results required to determine one of the following?

☐ If the individual is a candidate for an invasive diagnostic or therapeutic procedure of an internal body structure

☐ The appropriate anatomic location for an invasive procedure

☐ The extent of malignancy when recommended therapy reasonably depends upon the extent of malignancy

☐ More standard imaging modalities, (e.g., CT, MRI, or ultrasound) are either not indicated or unable to conclusively provide the required information

Is the scan for restaging or monitoring? ☐ YES ☐ NO

If yes, please answer the following:

Has the patient completed initial therapy for malignancy?

Are imaging results required to assess therapeutic success, in order to establish the need for, or scope of, any subsequent therapy?

Are scans to determine any of the following?

☐ Presence or extent of residual disease

☐ Presence or extent of recurrent disease

☐ Presence or extent of metastasis

☐ Other assessment of tumor response

Is this for surveillance purposes of known cancer or tumor? ☐ YES ☐ NO

When was the patient's last chemotherapy and/or radiation treatment? _____

_____

Was the cancer treated surgically? ☐ YES ☐ NO

If yes, when was the date of surgery? _____

What therapies are planned for this patient following the PET scan? _____

_____

_____

Has an MRI, CT scan or ultrasound been planned or has it already been performed? Please explain any results you may have for the preceding tests and when they occurred. If the test is being planned, when do you anticipate performing the test? _____

_____

_____

_____

Any additional information we should know regarding why this PET scan is being performed? _____

_____

_____

_____

**Provider Contact Information**

Contact Person: _____

Title: _____

Phone: _____

Fax: _____