

## Appendix B

### Prior Authorization Questionnaire - EXAMPLE

#### Request for Proposal Number 4759Z1

##### PA of PET Scans

Positron emission tomography (PET), also known as positron emission transverse tomography (PETT), or positron emission coincident imaging (PECI), is a noninvasive diagnostic imaging procedure that assesses perfusion and the level of metabolic activity in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images by detecting radioactivity from a positron emitting radioactive tracer substance (radiopharmaceutical) such as 2-[F-18] Fluoro-D-Glucose (FDG), that is administered intravenously to the patient.

1. **Assignment code** must be **Medical Diagnostic Services**
2. Select **Program** based on indication made below Prior Authorization (PA) or Physician Review (PE). Utilize check box to indicate primary diagnosis/codes that apply. (If \* indication requires physician review)

	Identify bone metastasis of cancer. (PA)	78811, 78812, 78813, 78814, 78815, 78816
	Brain tumor, Alzheimer's disease, dementias, intractable seizures (PA)	78608
	Myocardial imaging. (PA)	78459, 78491, 78492
	*Not one of the above diagnoses/codes- send for physician review (PE)	
	* <i>screening when the recipient has no signs or symptoms of disease</i> <b>Requires Physician Review</b>	

3.

Request for second PET scan < 90 days since last PET scan	
	Yes ( <b>send for physician review</b> )
	No (proceed to 4)

4.

Solid tumor	
	Yes (proceed to 5)

	No (proceed to 6)
--	-------------------

5.

Has tissue diagnosis been made: (PET scan is used for staging or restaging, not diagnosis)	
	Yes (proceed to 6)
	No ( <b>send for physician review</b> )

6. Does the clinical situation meet one of the following indicators:

(If yes to any of the situations below request may be approved **except for** \* indication which require physician review)

	assist in avoiding an invasive diagnostic procedure
	assist in determining the optimal anatomical location to perform an invasive diagnostic procedure
	replace one or more conventional imaging studies when it is expected that the conventional study information would be insufficient for the clinical management of the patient, and clinical management of the patient would differ depending on the state of the cancer.
	restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected reoccurrence or to determine the extent of a known reoccurrence
	Initial staging after diagnosis
	<i>*monitoring tumor response during the planned course of therapy when no change in therapy is being contemplated</i> <b>Requires Physician Review</b>
	<i>*None of the above indicators apply - Requires Physician Review</i>

Program Exception:

**Program** must be **PE** for all other diagnoses and/or requested HCPCS codes that are not reflected on the fee schedule.

---

Date: \_\_\_\_\_

Nurse Reviewer: \_\_\_\_\_

Due Date: \_\_\_\_\_

Recipient ID#: \_\_\_\_\_

PA/PE Number: \_\_\_\_\_

Nurses Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician Determination: Approved  Denied

Physician Rationale:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_