**FLORIDA HEALTH CARE PLANS – PET CT PRIOR AUTHORIZATION FORM**

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| --- | --- | --- | --- |
| Date: |       |  Authorization#: |       |
| Patient’s Name: |       | Date of Birth: |       |
| Phone#: |       | FHCP#: |       |
| Requesting Provider Name (First & Last) |       |
| Specialty: |       | Phone#: |       |
| Type of Referral: [ ] Routine  |
| ICD10 Diagnosis Code(s): |       |
| Code Description:  |       |
| **Select Radiotracer that applies:** |
| [ ]  Standard ***or*** Routine PET ***or*** PET/CT Imaging FDG (2 fluorine 18, fluoro 2 deoxy-d-glucose) Yes |
| [ ]  PET Bone Scan: Sodium 18F Fluoride PET/CT ***or*** [ ]  Other (describe)  |       |
|  |
| **REQUESTED LOCATION IF APPROVED:**       |
| **Reason for Study:** |
| [ ]  Initial Staging [ ]  Restaging [ ]  Interim PET/CT for Response-Adapted Therapy [ ]  Surveillance [ ]  Other |
| Currently on Chemotherapy:  | [ ] Yes [ ] No |
| Date completed Chemotherapy, if given:  |       |
| Currently on Radiotherapy:  | [ ] Yes [ ] No |
| Date Radiotherapy completed, if given:  |       |
| Does patient have known cancer spread to other parts of the body beyond primary tumor (Metastatic Disease)? [ ] Yes [ ] No |
| Is there suspicion of recurrence or progression based on signs, symptoms ***or*** imaging findings? [ ] Yes [ ] No |
| **COMPLETE THIS FORM AND FAX THE LAST 3 MONTHS OF PROGRESS NOTES TO:****FHCP CENTRAL REFERRAL DEPARTMENT**FAX: 386-238-3253 or 855-442-8398PHONE: 386-238-3230 or 800-352-9824 |
| \*\*\***This section is for internal use only\*\*\*** |
| DECISION: | [ ] APPROVED [ ] DENIED  |       |
| SIGNATURE: |  |  | DATE: |       |
| [ ]  Office notified of approval  |  Date & initials: |  |