Florida Health Care Plans®

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FLORIDA HEALTH CARE PLANS – PET CT PRIOR AUTHORIZATION FORM

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 855-442-8398
PHONE: 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: _____