Pre-PET Form
National Oncologic PET Registry

- You have requested a PET scan for an indication for which the Centers for Medicare and Medicaid Services (CMS) requires pre- and post-PET information prior to approving the study for reimbursement. In order for the imaging center to be reimbursed this form must be completed and returned to the PET facility before the PET scan is performed. You also will be required to complete a follow-up form after the PET scan is done. Thank you for your assistance completing the brief pre- and post-PET forms.

PET Facility ID #: _____ **Registry Case #: ___**

PATIENT INFORMATION

Date: _____/_____/_____

First Name: _____ Last Name: _____

Date of Birth _____/_____/_____

SSN#: _____

REFERRING PHYSICIAN

First Name: _____ Last Name: _____ UPIN#: _____

Office Telephone: (____) _____ Office Fax: (____) _____

Comment to Clinician: The required follow-up questionnaire will be sent to you by the PET facility.

The following definitions/instructions are provided to assist you in the completion of Question 1 ("SPECIFIC REASON FOR PET STUDY") on the next page of this form. This information is derived from the Medicare National Coverage Determination for PET.

< http://www.cms.hhs.gov/Transmittals/downloads/R31NCD.pdf>

Covered Indications for PET Scans and Limitations/Requirements for Usage

For all uses of PET relating to malignancies the following conditions apply:

Diagnosis: PET is covered only in clinical situations in which: (1) the PET results may assist in avoiding an invasive diagnostic procedure, or in which (2) the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are generally performed for staging rather than diagnosis.

> *Comment: PET under NOPR may be covered for **Diagnosis** (1) to help determine if a suspicious lesion is cancer, e.g., if the lesion is inaccessible for biopsy, if biopsy is contraindicated, or if biopsy has been done with indeterminate results; (2) to help find a primary tumor in a patient with pathologically proven (or strongly suspected) metastatic disease after negative results of conventional assessment, and (3) to help find a primary tumor in a patient with a strongly suspected paraneoplastic syndrome after negative results of conventional assessment.*

PET is not covered as a screening test (i.e., testing patients without specific signs and symptoms of disease).

Staging: PET is covered for staging *of a newly diagnosed cancer* in clinical situations in which: (1)(a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography (CT), magnetic resonance imaging (MRI), or ultrasound), or (1)(b) it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient, and 2) clinical management of the patient would differ depending on the stage of the cancer identified.

*Comment: PET under NOPR may be covered for **Staging** as a baseline when it is anticipated that PET will likely be used to monitor tumor response during treatment (see below).*

Monitoring: This refers to use of PET to monitor tumor response to treatment ***during*** the planned course of therapy (*i.e., when a change in therapy is anticipated*).

*Comment: As an example, PET performed under NOPR may be covered for **Monitoring** after 2 or 3 of a planned 6 cycles of chemotherapy in a patient considered not to be responding as expected.*

Restaging: PET is covered for restaging: (1) ***after*** completion of treatment for the purpose of detecting residual disease, (2) for detecting suspected recurrence or metastasis, (3) to determine the extent of a known recurrence, or (4) if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient. Restaging applies to testing after a course of treatment is completed, and is covered subject to the conditions above.

Comment: As noted above, PET is not covered as a screening test (i.e., testing patients without specific signs and symptoms of disease) and thus is not covered for surveillance of patients treated for cancer in whom there is no clinical reason to suspect recurrent disease.

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1. SPECIFIC REASON FOR PET STUDY

Check the single best match for the reason for the PET *(you must check only one of the following and then answer the section(s) indicated for question 2)*

- ❑ **Diagnosis**: To determine if a suspicious lesion is cancer (answer 2a and 2b)
- ❑ **Diagnosis/Unknown Primary Tumor**: To detect a primary tumor site in a patient with a confirmed or strongly suspected metastatic lesion (answer 2c)
- ❑ **Diagnosis/Paraneoplastic**: To detect a primary tumor site in a patient with a presumed paraneoplastic syndrome (answer 2a and 2b)
- ❑ **Initial Staging** of histologically confirmed, newly diagnosed cancer (answer 2a and 2b)
- ❑ **Monitoring Treatment Response** during chemotherapy (answer 2a and 2b)
- ❑ **Monitoring Treatment Response** during radiation therapy (answer 2a and 2b)
- ❑ **Monitoring Treatment Response** during combined modality therapy (e.g., chemo ± radiation ± surgery ± biologic therapy) (answer 2a and 2b)
- ❑ **Restaging** after completion of therapy (answer 2a and 2b)
- ❑ **Suspected Recurrence** of a previously treated cancer (answer 2a and 2b)

2. CANCER TYPE AND WORKING STAGE

- For a patient with a known primary or clinically suspected cancer, please mark the corresponding box of the cancer type in section 2a and answer question 2b. For a patient with metastatic disease of unknown primary origin, mark the corresponding box of the site of metastatic disease in section 2c. If your patient's cancer is not listed, check the Other box and enter as text the cancer type.

a. Cancer Type (ICD-9 Code) - *check the one cancer that most closely relates to the specific reason for the PET study indicated in response to Question 1. (Check only one)*

Note: The three-digit ICD-9 codes included on this form are for purposes of identifying the cancer type in the NOPR database, but the one selected is not necessarily the one that should be used for claim submission.

- ❑ Lip, Oral Cavity, and Pharynx (140-149)
- ❑ Esophagus (150)
- ❑ Stomach (151)
- ❑ Small Intestine (152)
- ❑ Colon (153) and Rectum (154)
- ❑ Anus (154)
- ❑ Liver and intrahepatic bile ducts (155)
- ❑ Gallbladder & extrahepatic bile ducts (156)
- ❑ Pancreas (157)
- ❑ Retroperitoneum and peritoneum (158)
- ❑ Nasal cavity, ear, and sinuses (160)
- ❑ Larynx (161)
- ❑ Lung, non-small cell (162)
- ❑ Lung, small cell (162)
- ❑ Pleura (163)
- ❑ Thymus, heart, mediastinum (164)
- ❑ Bone/cartilage (170)
- ❑ Connective/other soft tissue (171)
- ❑ Leukemia (204-208)
- ❑ Melanoma of skin (172)
- ❑ Female breast (174)
- ❑ Male breast (175)
- ❑ Kaposi's sarcoma (176)
- ❑ Uterus, unspecified (179)
- ❑ Cervix (180)
- ❑ Uterus, body (182)
- ❑ Ovary and uterine adnexa (183)
- ❑ Prostate (185)
- ❑ Testis (186)
- ❑ Penis and other male genitalia (187)
- ❑ Bladder (188)
- ❑ Kidney and other urinary tract (189)
- ❑ Eye (190)
- ❑ Primary Brain (191)
- ❑ Thyroid (193)
- ❑ Lymphoma (200-202)
- ❑ Myeloma (203)

❑ **Other, or not listed. Please describe cancer type:** _____

and give the first 3 digits of the ICD-9 code. ☐☐☐**.XX**

[Acceptable responses are 159, 165, 173, 181, 184, 192, 194, 195, and 235-238.

b. Has this cancer diagnosis been pathologically proven? ❑ Yes ❑ No

c. Unknown primary: site of pathologically proven or strongly suspected **metastatic disease** (196-199)

- ❑ Lymph node(s)
- ❑ Lung
- ❑ Liver
- ❑ Brain
- ❑ Bone/bone marrow

❑ **Other, or not listed. Please describe cancer type:** _____

and give the first 3 digits of the ICD-9 code. ☐☐☐**.XX [Acceptable responses are 196-199.]**

3. YOUR WORKING SUMMARY STAGE FOR THE PATIENT BEFORE THE PET SCAN IS?
(you must check only one)

- ❑ No evidence of disease / In remission
- ❑ Localized only
- ❑ Regional by direct extension or lymph node involvement or both
- ❑ Metastatic (distant) with a single suspected site
- ❑ Metastatic (distant) with multiple suspected sites
- ❑ Unknown or uncertain

4. PATIENT PERFORMANCE STATUS

Check the box best describing your patient's global functional status (ECOG Performance Score) *(you must check only one)*

- ❑ (0) Asymptomatic: *fully active, able to carry on all activities without restriction*.
- ❑ (1) Symptomatic, fully ambulatory: *restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature.*
- ❑ (2)Symptomatic in bed <50% of the day: *ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.*
- ❑ (3) Symptomatic in bed >50% of the day, but not bedridden: *capable of only limited self-care, confined to bed or chair 50% or more of waking hours.*
- ❑ (4) Bedridden: *Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.*

5. MANAGEMENT PLAN

a. If PET were not available, your current **management strategy** would be? *(you must check only one)*

- ❑ **Observation** (with close follow-up)
- ❑ **Additional Imaging** (CT, MRI) or other non-invasive diagnostic tests
- ❑ **Tissue Biopsy** (surgical, percutaneous, or endoscopic).
  Note: If concurrent biopsy and total surgical resection are planned, then mark "surgical" treatment below.
- ❑ **Treatment**

b. If Management Plan checked above is "Treatment" complete this section.

Treatment Goal: *(check one)* ❑ Curative ❑ Palliative

Type(s): *(check all that apply)* ❑ Surgical ❑ Chemotherapy (including biologic modifiers)
❑ Radiation ❑ Other ❑ Supportive care

❑ Yes ❑ No **Will treatment be directly provided by you?** *(check one)*

6. NAME OF PERSON WHO COMPLETED THE PAPER FORM

First Name: _____ Last Name: _____ Date _____

Thank you for your assistance.