Statement of Medical Necessity

for Pheochromocytoma or Paraganglioma

PATIENT INFORMATION

First Name: MI: Last Name:

DOB: / / Gender: ☐ Male ☐ Female

Address:

City: State: Zip Code:

☐ Home Phone: ( ) - ☐ Cell Phone: ( ) - ☐ Ok to leave message

DIAGNOSIS

Date of Diagnosis (MM/DD/YYYY): / /

☐ iobenguane scan positive, unresectable, locally advanced or metastatic **pheochromocytoma** in adult and pediatric patients 12 years and older

☐ iobenguane scan positive, unresectable, locally advanced or metastatic **paraganglioma** in adult and pediatric patients 12 years and older

Methods of Diagnosis (check all that apply):

☐ Biochemical plasma test ☐ Biochemical 24-hour urine test ☐ Histopathology ☐ MIBG scan ☐ SPECT

☐ Octreotide scan ☐ CT/MR/PET scan ☐ Genetic testing:

Additional Diagnosis Information:

MEDICAL ASSESSMENT

Date of Evaluation (MM/DD/YYYY): / / Metabolites:

Presence of Metastasis (Imaging Studies):

Pain and Symptom Presentation: Tumor Markers:

Summary:

PREVIOUS THERAPIES TRIED/FAILED

☐ Surgical Resection: ☐ Targeted cancer therapies:

☐ Chemotherapy: ☐ Radiotherapies:

PHYSICIAN AUTHORIZATION

I certify the above information is medically necessary and the information provided is correct to the best of my knowledge.

Administering Provider Name:

NPI #:

Administering Facility Name:

Facility Address:

City: State: Zip Code:

/ /

Prescriber Signature **Date**

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