# 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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