



Controlled Unclassified Information

Submission Instructions: Please refer to the Endometrial Cancer and Endometrial Intraepithelial Neoplasia (Uterine Cancer) Medical Coverage Determination (MCD) when completing this form. Please apply the following naming convention for labeling the PA3 Fertility-Sparing Treatment request PDF: PA3-Fertility-Sparing Treatment [respective CCE/NPN]. Send the completed form to the WTC Health Program by posting it to the CARE Portal, or the SFTP server and then send a Personally Identifiable Information (PII)-free e-mail to WTCMedCode@csra.com, indicating the secure server posting of this request. Incomplete forms will be sent back for more information. Please do not submit any other additional information or documents unless specifically requested by NIOSH.

Request Information

Table with 4 columns: Request Date, Request Type, Date of Last Provider Visit, Date of Last Authorization

Member and Provider/Requester Information

Form sections: Member Information (Last, First, MI, Date of Birth, Member #, Member Type), Provider Information (CCE/NPN, Requesting Provider Name, Requesting Provider Credentials, Requesting Provider Email, Requesting Provider Phone, Requesting Provider Fax)

WTC-Related Conditions

Table with 2 columns: ICD-10 Code, Condition

Fertility-Sparing Treatment Related Service Request

A billable medical code is required

Procedure/CPT Code	Description	Estimated Fee
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Treatment Plan

The PA3 request for fertility-sparing treatment will only cover a 12 calendar-month authorization period. Once the PA3 is approved, the authorization period starts the day the member begins receiving fertility-sparing treatment and ends when the 12 calendar-month period is over, unless a new PA3 is submitted to the WTC Health Program. The WTC Health Program-affiliated provider must furnish a plan of care to the CCE/NPN Clinical Director prior to the end of the current authorization period, and before the start of each new authorization period. The CCE/NPN Clinical Director must submit a new PA3 request and the WTC Health Program must approve the request, reconfirming that the member's fertility-sparing treatment is appropriate and all criteria in the MCD are met.

Plan of Care

For subsequent requests: The WTC Health Program-affiliated provider must furnish a plan of care to the CCE/NPN Clinical Director prior to the end of the current authorization period, and before the start of each new authorization period.

Fertility-Sparing Services Rationale

By initialing to the right of each* of the statements below, the CCE/NPN Clinical Director attests that all of the following statements are applicable:

EIN or Grade 1 endometrioid adenocarcinoma on surgical pathology (D&C)

Disease limited to endometrium on imaging (MRI/TVUS)

Absence of metastatic disease on imaging

No contraindications to pregnancy

No contraindications to medical management of EIN or Grade 1 endometrioid adenocarcinoma

Documentation patients have been counseled that medical management is not standard of care

Clinical Director Concurrence

I certify that for the services requested and cited above, a Level 3 prior authorization has been granted by me based upon the corresponding requirements in the applicable MCD. This approval and all associated required documentation of policy requirements and medical necessity is being maintained in the member's medical record or other CCE/NPN tracking system.

CCE/NPN Clinical Director Signature _____ **Date**_____

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Decision

Decision Comments

Required for NIOSH reviewer. If denied, provide clinical rationale and specific reasons for denial, outlining which MCD criteria were not met.

NIOSH Staff Signature _____

Date _____