



## MATER PET/CT CENTRE

*A public/private partnership between  
Mater Misericordiae University Hospital and Mater Private Hospital*

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### VHI Prior Approval Form

Please find attached 4-page VHI prior approval form for a PET/CT Scan. This needs to be completed in full and signed by the **consultant in charge** (it must be signed by him/her only) and **signed by the patient**. Please note that **all relevant CT, histology, MRI etc reports must accompany this form**. Also, please attach a referral letter outlining the clinical indications for the scan, this referral should also include contact details for both the patient and the consultant.

When completed, please **fax or email** the attached form to the PET/CT unit at 01-8034989 or [materpetct@materprivate.ie](mailto:materpetct@materprivate.ie). The prior approval form will then be submitted immediately to VHI and the patient will be contacted with an appointment if VHI approve the claim. (This can sometimes take up to 72hrs). Please be aware that sending back an incomplete form can delay the patient's appointment, so kindly make sure all sections are completed.

Prior to a PET/CT Scan, the patient will need one day to prepare for the scan (by following a set diet).

If you have any other queries, please do not hesitate to contact the undersigned.

Kind regards,

Bernie/Barbara  
**PET/CT Secretary**  
**Tel: 01 8034970**  
**Fax: 01 8034989**  
**Email: [materpetct@materprivate.ie](mailto:materpetct@materprivate.ie)**

If all of the pages are not received or are illegible, please don't hesitate to contact us.

**DATA REQUIRED FOR  
PRE-CERTIFICATION FOR PET SCANNING**

**I UNDERSTAND THAT PET SCANS ARE SUBJECT TO PRE-CERTIFICATION BY VHI HEALTHCARE AND I AUTHORISE THE DOCTORS/HOSPITALS TO SUPPLY THE INFORMATION REQUESTED, INCLUDING ACCESS TO MY HOSPITAL/MEDICAL RECORDS, IF REQUESTED.**

**Member's Signature:** \_\_\_\_\_

**A. Essential Pre-certification Information**

*Questions 1 – 22 must be completed in full*

1. PET scan facility name

2. Subscriber's name

3. Patient's name

4. Patient's date of birth

5. Address

6. Membership number

7. Plan type

8. Name of referring consultant:

\_\_\_\_\_  
Vhi Doctor Code:

9. Name of referring hospital:

\_\_\_\_\_  
Vhi Hospital Code: \_\_\_\_\_

10. In-patient

Yes  No

11. General Conditions  
Notes:

- A) Benefit for PET-CT scans is limited to the specific clinical indications outlined below.
- B) Benefit for staging scans will be provided for the indications as specified below when the cancer is biopsy proven.
- C) Benefit for re-staging will be provided for the indications as specified below (unless otherwise limited by the specific clinical indication):
  - (i) after completion of treatment to detect residual disease
  - (ii) to determine the extent of a known recurrence or
  - (iii) where a recurrence or metastases are strongly suspected in symptomatic patients who have been identified as having a definitive clinical abnormality, either on clinical examination or as a result of other investigations, that is consistent with a recurrence of a previously diagnosed cancer.
- D) Benefit is not provided for PET for monitoring tumour response during the planned course of therapy except for (a) breast cancer as outlined below and (b) after 2 cycles of treatment in lymphoma if the information provided will be used to alter the management.

**All relevant documentation must be provided with the request.**

12. Specific Clinical indication for PET scan – please tick one of the following:

Clinical Indication	Clinical Indication Description	Please Tick Appropriate Indication
389	Characterisation of an indeterminate solitary pulmonary nodule (SPN) > 1cm and < 4cm. <i>Note: Benefit is only provided when it is medically necessary to distinguish between a malignant primary lesion of lung and a benign lesion and not when there is or has been a diagnosis of a primary cancer elsewhere</i>	
390	Staging of non-small cell lung cancer (except for Stage IV, M1a with pleural or pericardial effusion)	
391	Staging of invasive non-metastatic colo-rectal cancer when abnormalities (>= 1 cm) are identified on CT or MRI scan that are considered to be suspicious but inconclusive for metastases, provided further delineation will change management	
392	Pre-operative staging of metastatic colo-rectal cancer only if prior anatomic imaging (CT or MRI) indicates the presence of potentially surgically curable metastatic disease	
393	Re-staging colo-rectal cancer in the scenario of an elevated CEA with negative good-quality CT scans	
394	Staging of Hodgkin's or non-Hodgkin's lymphoma	
395	Re-staging of Hodgkin's or non-Hodgkin's lymphoma	
396	Staging of patients with stage IV malignant melanoma	
397	Re-staging of patients with local recurrence of melanoma	
398	Staging and re-staging of oesophageal cancer	
399	Staging of stage III and IV head and neck cancers	
400	Re-staging of head and neck cancer post completion of chemotherapy and/or radiotherapy	
401	Staging of T4 and/or N2 breast cancer only when standard imaging studies (bone scan and CT scans) are equivocal or suspicious	
402	Re-staging of recurrent breast cancer (either know or strongly suspected as outlined in general condition (iii) above) when other imaging studies (bone scan and CT or MRI scans) are equivocal and biopsy of the equivocal or suspicious site is not feasible	

403	Monitoring response to treatment for metastatic breast cancer only when other imaging studies (bone scan and CT or MRI scans) are shown to be equivocal	
404	Staging of anaplastic thyroid cancer	
405	Re-staging of papillary or Hurthle cell carcinoma previously treated by thyroidectomy and radio-iodine ablation with an elevated serum Tg > 10ng/ml and stimulated Tg > 2-5 ng/ml and negative I-131 imaging	
406	Re-staging of medullary carcinoma of thyroid when serum calcitonin levels are > 500pg/ml	
407	Detection of pre-treatment metastases (staging) in newly diagnosed cervical cancer or re-staging of previously treated cervical cancer	
408	Re-staging of ovarian cancer	
409	Re-staging of men with seminoma post chemotherapy with a residual mass > 3 cm and normal markers	
410	Staging of small cell lung cancer	
411	Staging and re-staging of gastric cancer	
412	Staging and re-staging of multiple myeloma	
413	Staging and re-staging of osteosarcoma and Ewing's sarcoma family of tumours	
414	Staging and re-staging of soft tissue sarcomas	
415	Occult primary – staging in carcinomas of unknown primary site in tumours of indeterminate histology where the primary site cannot be identified by endoscopy or other imaging (CT, MRI) and where loco-regional therapy for a single site of disease is being considered	
416	Staging of neuro-endocrine tumours of unknown primary site	
417	Staging of pancreatic cancer	
418	Staging of hepatobiliary cancer other than hepatocellular cancer	
419	Staging of thymomas and thymic cancer	
420	Pre-surgical evaluation of patients with refractory seizures for the purpose of localisation of a focus of the refractory seizure activity	
13. Date of patient's first consultation regarding this particular problem		
14. Nature of symptoms		
15. Duration of symptoms prior to first consultation		
16. Have there been previous episodes of this or of a related illness? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please give details		

17.	Please specify all investigations performed and provide copies of the results (and specifically histology reports and in the case of SPN, the CT report) that support the final diagnosis <b>Investigations:</b> <span style="margin-left: 150px;"><b>Findings:</b></span>
18.	Has an MRI been performed? Yes <input type="checkbox"/> No <input type="checkbox"/> <b>If yes, please provide copy of result</b>
19.	Has a CT been performed? Yes <input type="checkbox"/> No <input type="checkbox"/> <b>If yes, please provide copy of result</b>
20.	In the case of suspected recurrent disease has conventional imaging or other investigations failed to confirm a recurrence? Yes <input type="checkbox"/> No <input type="checkbox"/>
21.	Will CT, MRI, ultrasound or other investigations identify the stage of the disease? Yes <input type="checkbox"/> No <input type="checkbox"/> <b>If no, will the PET scan both replace their use and alter the clinical management of the patient?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
22.	Based on investigations to date and in the absence of a PET scan, please specify current proposed future management of the patient
<b>CERTIFICATION</b> I hereby certify that the PET scan was necessitated by the illness described by me above  <b>Consultant's Signature:</b> _____ <b>Vhi Doctor Code:</b> _____	
<b>PRE-CERTIFICATION DECISION – FOR COMPLETION ONLY BY VHI'S MEDICAL ADVISORS</b>  Is the PET scan eligible for benefit in accordance with Vhi Rules? Yes <input type="checkbox"/> No <input type="checkbox"/>  <b>Date:</b> _____ <b>Signed On Behalf of Vhi Healthcare:</b> _____	