NEW iDEAS

Imaging Dementia—Evidence For Amyloid Scanning

PET Imaging Facility
Case Report Form Packet

Version 2 – December 2021

Contents

Document Version History

Version #	Significant Changes	Section	Effective Date
1.0	Initial Launch of Case Report Forms	N/A	DECEMBER 2020
2.0	Date of Birth Verification Addition of Coinsurance Reimbursement Form	PET Assessment Form Coinsurance Reimbursement Form	DECEMBER 2021

Amyloid PET Completion Form

Instructions: This form is completed by the PET Facility via Web-based data entry within 7 days of the day the scan was performed.

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1. Date scan completed [MM/DD/YYY]: _____
   (must be within 60 days of Pre-PET Clinical Assessment form submission)

2. Scan Type:
   - PET
   - PET-CT
   - PET-MRI

3. Radiopharmaceutical:
   - F-18 florbetaben (Neuraceq™)
   - F-18 florbetapir (Amyvid™)
   - F-18 flutametamol (Vizamyl™)

4. Net Administered Dose at Injection Time: _____ (mCi)

   Reason dosage falls outside of protocol limits: *[free text]*

   _____

   _____

5. Time of Radiopharmaceutical Injection *[XX:XX]*: _____ (AM/PM)
   (Time recorded should match that entered into DICOM header)

6. Scan Start Time *[XX:XX]*: _____ (AM/PM)
   (Time recorded should that shown in DICOM heard. If more than one acquisition was performed because of patient motion, the time recorded should be for the series uploaded to image archive.)

7. Scan Duration: _____ (Minutes)

Name of Person responsible for the data on this form: _____

Form submission date: _____

Amyloid PET Report Form

Instructions: This form is used to transmit the Amyloid PET Report. It is completed by the PET facility via Web-based data entry within 7 days after completing the Amyloid PET scan.

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1. Date Pet Report Completed [MM/DD/YYY]: _____

2. Interpreting Physician Information: *[Drop down menu of approved pysicians]*

3. PET Report:

   Enter the COMPLETE PET REPORT as free text. Copy & paste from Microsoft Word document or other text document

4. Please certify that the text pasted above contains all text from the ENTIRE PET report for this scan.

   ☐ I certify that the text pasted above contains the entire PET report for this patient's amyloid PET scan.

Name of Person responsible for the data on this form: _____

Form submission date: _____

Amyloid PET Assessment Form

Instructions: The radiologist/nuclear medicine physician who interprets the amyloid PET is required to complete the online Amyloid PET Assessment Form within 7 days of the scan.

Patient's Date of Birth [*MM/DD/YYY*]: _____

Note: Verifying the patient's DOB serves as a safeguard to ensure the correct patient's data is being entered and submitted.

1. Radiopharmaceutical:

   - ○ F-18 florbetaben (Neuraceq™)
   - ○ F-18 florbetapir (Amyvid™)
   - ○ F-18 flutametamol (Vizamyl™)

2. Scan Type:
   - ○ PET only
   - ○ PET/CT
   - ○ PET/MRI

3. Was image quantification used to assist in interpretation?
   - ○ No
   - ○ Yes

4. Was comparison with prior brain imaging studies used to assist in interpretation?
   - ○ No
   - ○ Yes

   If yes, select one or more of the following and provide date for each selected:

   - ☐ CT
     Date of CT:_____/_____/_____
   - ☐ MRI
     Date of MRI:___/_____/_____
   - ☐ FDG-PET
     Date of FDG-PET:_____/_____/_____
   - ☐ Other, specify: _____
     Date of Other:___/_____/_____

5. Scan Quality Assessment:
    - Adequate (complete item 6)
    - Suboptimal, but interpretable (complete item 6)
    - Uninterpretable/ technically inadequate (provide reason(s))

        If uninterpretable/technically inadequate study, specify reason(s):
        - ☐ Patient motion
        - ☐ Image too noisy
        - ☐ Image artifact
        - ☐ Other, specify: _____

6. Global Scan Result:
    - Positive for cortical beta-amyloid
    - Negative for cortical beta-amyloid

    If positive or negative, provide confidence level of interpretation:
    - Low
    - Intermediate
    - High

Name of Person responsible for the data on this form: _____

Form submission date: _____

Coinsurance Reimbursement Form

Instructions: Ensure that all the following items have been completed prior to submitting a request for reimbursement. The study sponsor will only reimburse the coinsurance that the study participant otherwise would owe for the amyloid PET scan used in the study, as documented by the Medicare Explanation of Benefits (EOB). Allowable components of the coinsurance amounts include technical, professional, or global charges. Fixed co-payments are also considered reimbursable charges under this program. Sponsor will not reimburse for charges related to the patient's deductible. This form should not be completed by an industry representative and should only be submitted once all applicable insurers have been billed and EOBs obtained. Send any questions, comments, or special circumstances to the New IDEAS Study Team at NewIdeas@acr.org.

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1. **General Information** ***(This information is auto populated. Contact the study team if a discrepancy is identified.)***
   a) Provider type:
      - o Hospital-based
      - o Not hospital-based (physician office or independent diagnostic testing facility)

   b) Medicare type:
      - o Traditional Medicare
      - o Medicare Advantage (MA Plan)

   c) Supplemental insurance?
      - o Yes
      - o No

   d) Scan was performed on [*MM/DD/YYYY*]: _____

   e) Radiopharmaceutical Administered: _____

2. **Required Documentation:**
   a) Upload the Explanation of Benefits (EOB) document(s) as proof of required patient coinsurance for the amyloid PET scan. If facility does not charge globally, then both professional and technical (including the radiopharmaceutical) EOBs must be uploaded. **Note: EOB amounts should match requested amounts provided in question 4 below.**

3. **Attestation of Coverage**
   - o The PET Facility attests that the patient does not have Medicare supplemental insurance (e.g,. Medigap or Medicaid for a dual-eligible patient) or, has a MA plan, that will not cover the cost of the coinsurance of the amyloid PET scan.

     OR

   - o The PET Facility has reviewed with the IDEAS staff or reimbursement consultant that, for reasons other than above, the plan will not cover the coinsurance for the amyloid PET scan.

     Provide additional details of the situation (including name of the plan): [*Free Text Box*]

4. **Total Amounts Requested for reimbursement.**
   Note: amount(s) must match the coinsurance shown on EOB(s). If facility bills globally, insert total amount in 4a, professional charges.

   a) Coinsurance amount for professional (or global) charges: _____

   b) Coinsurance amount for technical charges (including radiopharmaceutical): _____

By submitting this form, I certify that all information provided above is correct to the best of my knowledge.

Name of person submitting the form: _____

Submission Date [*MM/DD/YYYY*]: _____