Eviti Imaging: Prostate Cancer

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Please note the following:

For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Please refer to the CMS website at http://www.cms.gov for additional information.

For Medicaid members/enrollees, circumstances when state Medicaid coverage provisions conflict with the coverage provisions within this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Prostate Cancer Imaging

Discussion

This imaging guideline provides a standardized framework for the use of diagnostic and surveillance imaging in the management of common adult malignancies, specifically prostate cancer. The goal is to ensure timely, evidence-based imaging that supports accurate staging, treatment planning, response assessment, and post-treatment surveillance.

Guiding Principles

- Follow evidence-based practices from major guidelines (e.g., NCCN, ESMO, ACR Appropriateness Criteria)
- Ensure imaging aligns with the clinical context and stage of disease
- Minimization of unnecessary radiation exposure
- Promote timely and cost-effective imaging utilization
- Incorporate multidisciplinary collaboration in imaging decisions

Imaging Guidelines

This guideline applies to the following patients:

1. At least 18 years of age with confirmed or suspected diagnoses of prostate cancer; AND
2. All phases of oncologic care, including one of the following:
   a) Initial staging
   b) Treatment response evaluation
   c) Post-treatment surveillance
   d) Detection of recurrence or progression; AND
3. All imaging modalities used in oncology care, including but not limited to the following:
   a) Computed Tomography (CT) (neck, chest, abdomen, pelvis, neck, or site-specific)
   b) Magnetic Resonance Imaging (MRI) (including site-specific protocols such as pelvis MRI, brain MRI, liver MRI)
   c) Fluorodeoxyglucose Positron Emission Tomography/CT (FDG-PET/CT)
   d) PET/MRI
   e) Somatostatin Receptor PET/CT (SSTR-PET/CT)
   f) Nuclear Medicine (e.g., bone scan, PSMA PET)
   g) Single Photon Emission Computed Tomography/CT (SPECT/CT) (e.g., octreotide SPECT/CT for neuroendocrine tumors)

Notes:

1. The concurrent utilization of multiple advanced imaging modalities—such as PET/CT and MRI—is not routinely warranted and should be considered only when each modality is expected to provide distinct and clinically relevant information that will directly impact patient management. The selection of the most appropriate imaging study should be individualized, taking into account tumor type, clinical presentation, prior imaging, and other patient-specific factors. Imaging requests will be evaluated on a case-by-case basis to ensure clinical necessity, appropriateness, and the potential to influence therapeutic decision-making.

2. When PET imaging is clinically indicated, the appropriate radiotracer should be selected based on tumor type and clinical scenario.

Prostate Cancer Imaging

1. Imaging for initial risk stratification and staging
2. Assessment for biochemical recurrence
3. Advanced imaging for metastatic or castration-resistant disease

Prostate cancer imaging supports accurate risk stratification, staging, and assessment of treatment response or recurrence. Imaging strategies vary by disease risk category (low, intermediate, high), presence of symptoms, and biochemical recurrence after initial therapy. Advanced imaging techniques such as multiparametric MRI and PSMA PET have significantly enhanced diagnostic accuracy.

Prostate Cancer Imaging Recommendations			
Clinical Scenario	**Recommended Modality**	**Frequency/Timing**	**Purpose/Notes**
Initial Diagnosis (Elevated PSA/Abnormal Digital Rectal Exam)	Multiparametric MRI (mpMRI) and MRI pelvis+/- abdomen	Prior to biopsy	Guides targeted biopsy and decide appropriateness of active surveillance; improves detection of clinically significant cancer
Initial Staging (High-Risk or Unfavorable Intermediate-Risk)	CT chest/abdomen/pelvis + Bone scan or PSMA PET/CT	At diagnosis	PSMA PET preferred where available; superior to conventional imaging
Low-Risk/Favorable Intermediate-Risk	No routine imaging unless symptomatic or concern for metastasis	N/A	Imaging is usually not indicated unless clinical concerns exist
Post-Treatment Surveillance (Radiation or Surgery)	PSA monitoring	Every 6–12 months Every 3-4 months on ADT (as per guideline)	Routine imaging is not indicated
Active Surveillance	Multiparametric MRI (mpMRI)	Every 12 months	
Biochemical Recurrence (Rising PSA Post-Radical Prostatectomy or	PSMA PET/CT	At time of recurrence	High sensitivity for detecting local or distant recurrence

Radiation Therapy)			
Suspected Local Recurrence (Post-Radiation)	Multiparametric MRI (mpMRI) and MRI pelvis+/- abdomen	As clinically indicated	Evaluate for local recurrence, especially if salvage therapy is considered
Known Metastatic Disease (mHSPC or mCRPC) Follow-Up	CT chest/abdomen/ pelvis +/- Bone scan PSMA PET/CT (When clinically indicated due to inconclusive or inadequate findings on conventional imaging)	Every 3–6 months (based on therapy)	Monitor for disease progression and treatment response
Bone Metastases Follow-Up	Bone scan PSMA PET CT (When clinically indicated due to inconclusive or inadequate findings on conventional imaging)	Every 6–12 months or as needed	Monitor skeletal disease burden
Symptom-Driven Imaging	MRI spine Bone scan CT PSMA PET; when clinically indicated due to inconclusive or inadequate findings on conventional imaging)	As needed	For new pain, neurological symptoms, or concern for progression

Notes:

1. PSMA PET/CT is now the preferred imaging modality in many settings, particularly in biochemical recurrence and staging of high-risk disease.
2. Multiparametric MRI plays a vital role in both diagnosis and post-treatment evaluation, particularly in local recurrence assessment.
3. Imaging should always be guided by clinical risk factors, PSA kinetics, and symptomatology.
4. When PET imaging is clinically appropriate, prostate-specific membrane antigen (PSMA) PET is the preferred modality. In settings where PSMA PET is not available, alternative tracers such as ^{18}F-fluciclovine PET/CT or ^{11}C-choline PET/CT may be considered acceptable substitutes.[1]

Revision and Review History

No.	Description	Date
1	Original Effective Date:	1/1/2026
2	Policy Annual Review Dates:	
3	Department Owner:	Medical Affairs
4	NH Advisory Committee Approval Dates:	
5	Revision Changes:	

References

[1] National Comprehensive Cancer Network Guidelines: Prostate Cancer. https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed December 15, 2025.