Central Nervous System (CNS) Metastatic Cancer
Radiation Therapy Treatment Plan Checklist

NIA has provided this checklist to assist you in gathering the clinical and treatment plan information needed to request a medical necessity review. The most efficient way to submit a review request is via www.RadMD.com or call the NIA Call Center toll free number. Please do not fax the checklist to NIA.

### General Information

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>DOB:</th>
<th>Health Plan ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Oncologist:</td>
<td></td>
<td>Breast Surgeon:</td>
</tr>
<tr>
<td>Radiation Therapy Facility:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Planning Start Date (i.e. Initial Simulation):</td>
<td>Anticipated Treatment Start Date:</td>
<td></td>
</tr>
</tbody>
</table>

### Patient Clinical Information

#### Brain Metastasis

- Site of primary cancer: [ ] Bladder [ ] Breast [ ] Colorectal [ ] Head/Neck [ ] Lung [ ] Prostate [ ] Other ___________
- Active cancer in another organ system: [ ] Yes [ ] No [ ] Unknown
- Receiving radiation treatment to another site: [ ] Yes [ ] No [ ] Unknown
- If systemic disease, is it controlled: [ ] Yes [ ] No [ ] Unknown
- How many lesions are present: ______________ Size of lesions in cm: ______________
- Has patient undergone surgery for brain lesion(s): [ ] Yes [ ] No [ ] Unknown
- Prior radiation to the head: [ ] Yes [ ] No [ ] Unknown
- Whole brain or partial brain treatment planned: [ ] Whole Brain [ ] Partial Brain (No WBRT) [ ] Unknown
- What is the patient’s performance status? (ECOG Scale)
  - 0 – Fully active, able to carry on all pre-disease performance without restriction
  - 1 – Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature
  - 2 – Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
  - 3 – Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
  - 4 – Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair

#### Spine Metastasis

- Tumor amenable to surgery: [ ] Yes [ ] No [ ] Unknown
- Tumor causing intractable pain: [ ] Yes [ ] No [ ] Unknown
- Tumor causing spinal cord compression: [ ] Yes [ ] No [ ] Unknown

#### Other Metastasis

- Why is the patient receiving radiation treatment: ________________
- Treatment intent/timing: [ ] Primary [ ] Adjuvant radiation therapy [ ] Unknown
- Initial or recurrent tumor: [ ] Initial Tumor [ ] Recurrent Tumor [ ] Unknown

### Treatment Planning Information

- What is the prescription radiation dose for the ENTIRE course of external beam treatment? __________ Gy

#### Initial Treatment Phase – Select Therapy

<table>
<thead>
<tr>
<th>2-Dimension</th>
<th>3D Conformal</th>
<th>IMRT</th>
<th>SRS/SBRT</th>
<th>Proton</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDR Brachytherapy</td>
<td>LDR Brachytherapy</td>
<td>Other __________</td>
<td></td>
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Fractions: ______

**IMRT ONLY:**

- Which technique will be used? [ ] Linac Multi-Angle [ ] Compensator-Based [ ] Helical [ ] Arc Therapy [ ] Other

**Note:** IMRT treatment requests may be reviewed for medical necessity by a radiation oncologist. Clinical rationale for performing IMRT is required and should include a comparison 3D-CRT plan, tissue constraints and target goals of the plan and evidence of inverse planning. Field in field or forward planning is not considered IMRT.

**SRS/SBRT ONLY:**

- Which technique will be used? [ ] Robotic Linac Multi-Angle [ ] Robotic - Tomotherapy [ ] Robotic - CyberKnife
  - [ ] Non-Robotic - Linac Multi-Angle [ ] Non-Robotic - Tomotherapy [ ] Non-Robotic - Gamma Knife
  - [ ] Unknown [ ] Other __________
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**Boost Phase 1 – Select Therapy**

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**IMRT ONLY:**

Which technique will be used? Linac Multi-Angle Compensator-Based Helical Arc Therapy Other

*Note:* IMRT treatment requests may be reviewed for medical necessity by a radiation oncologist. Clinical rationale for performing IMRT is required and should include a comparison 3D-CRT plan, tissue constraints and target goals of the plan and evidence of inverse planning. Field in field or forward planning is not considered IMRT.

**SRS/SBRT ONLY:**

Which technique will be used? Robotic Linac Multi-Angle Robotic - Tomotherapy Robotic - CyberKnife Non-Robotic - Linac Multi-Angle Non-Robotic - Tomotherapy Non-Robotic - Gamma Knife Unknown Other ______________

**LDR ONLY:**

If any portion of the patient’s radiation oncology treatment will be performed in a facility or hospital other than the facility previously stated, what is the name of that facility? ___________________________________________________________________________________

Which portion of the treatment will be performed at the additional facility? NA Initial Phase Boost Phase

**Boost Phase 2 – Select Therapy**

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**IMRT ONLY:**

Which technique will be used? Linac Multi-Angle Compensator-Based Helical Arc Therapy Other

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**SRS/SBRT ONLY:**

Which technique will be used? Robotic Linac Multi-Angle Robotic - Tomotherapy Robotic - CyberKnife Non-Robotic - Linac Multi-Angle Non-Robotic - Tomotherapy Non-Robotic - Gamma Knife Unknown Other ______________

**LDR ONLY:**

If any portion of the patient’s radiation oncology treatment will be performed in a facility or hospital other than the facility previously stated, what is the name of that facility? ___________________________________________________________________________________

Which portion of the treatment will be performed at the additional facility? NA Initial Phase Boost Phase