NIA
A Magellan Health Company

Non- Small Cell Lung 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

Patient Name :	DOB:	Health Plan ID :
Radiation Oncologist :	Radiation Therapy Facility :	
Treatment Planning Start Date (i.e. Initial Simulation) :	Anticipated Treatment Start Date :	

Patient Clinical Information

✓ **Treatment Intent :** ☐ Pre -Operative ☐ Post Operative- Adjuvant ☐ Primary Therapy- Definitive Medically Inoperable ☐ Primary Therapy -Surgically Inoperable ☐ Palliative – Surgically Inoperable

T Stage:	N Stage:	
☐ TX ☐ T0 ☐ Tis ☐ T1 ☐ T2 ☐ T3 ☐ T4	☐ NX ☐ N0 ☐ N1 ☐ N2 ☐ N3 **Does patient have distant metastasis (M1)?** ☐ Yes ☐ No	✓ **If palliative, what is the reason for radiation therapy? (e.g. airway obstruction, hemoptysis pain, etc.)** ✓ **Margin Status (Post Operative Only):** ☐ Negative ☐ Close ☐ Positive ☐ Not Applicable ✓ **Is there extracapsular nodal extension ?** ☐ Yes ☐ No ✓ **Is chemotherapy planned :** ☐ Yes ☐ No

Treatment Planning Information

1. Initial Treatment Phase (Select Therapy for Initial Phase of Treatment)

☐ **2-Dimension Radiation Therapy:**	✓ Number of ports:	✓ Fractions :	✓ Total Course Dose (Gy) :
✓ Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined?			☐ Yes ☐ No
☐ **3D Conformal Radiation Therapy:**	✓ Number of ports:	✓ Fractions :	✓ Total Course Dose (Gy) :
✓ Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined?			☐ Yes ☐ No
☐ **Intensity Modulated Radiation Therapy:**	✓ Number of ports/arcs:	✓ Fractions :	✓ Total Course Dose (Gy) :
✓ Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined?			☐ Yes ☐ No
✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Compensator-Based ☐ Helical ☐ Arc Therapy ☐ Other			
☐ **High Dose Rate (HDR) Brachytherapy:**	✓ Fractions :		
✓ Will a tumor volume and at least one critical structure be contoured for brachytherapy planning?			☐ Yes ☐ No
☐ **Stereotactic Body Radiation (SBRT):**	✓ Number of ports:	✓ Fractions :	✓ Total Course Dose (Gy) :
✓ Which technique will be used? ☐ Robotic -Linac Multi-Angle ☐ Robotic- Tomotherapy ☐ Robotic -Cyberknife ☐ Non -Robotic			
☐ **Image Guidance (IGRT) Technique:** ☐ None ☐ CT Guidance ☐ Stereoscopic with fiducial markers ☐ Other			

Requests for special dosimetry (CPT® 77331), special physics consultation (CPT® 77370) and special treatment procedure (CPT® 77470) require clinical rationale for review. Please note the rationale for each service at the end of the checklist.

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2. Boost Phase # 1 (Select Therapy for Boost Phase)		
☐ **2-Dimension Radiation Therapy:**	✓ Number of ports:	✓ Fractions :
✓ Will a new CT be performed?		☐ Yes ☐ No
☐ **3D Conformal Radiation Therapy:**	✓ Number of ports:	✓ Fractions :
✓ Will a new CT be performed?		☐ Yes ☐ No
☐ **Intensity Modulated Radiation Therapy:**	✓ Number of ports/arcs:	✓ Fractions :
✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Compensator-Based ☐ Helical ☐ Arc Therapy ☐ Other		
✓ Will a new CT be performed?		☐ Yes ☐ No
☐ **Other**	✓ Number of ports:	✓ Fractions :
✓ What is the other type of boost for the first boost treatment?		
☐ **Guidance (IGRT) Technique:** ☐ None ☐ CT Guidance ☐ Stereoscopic with fiducial markers ☐ Other		
3. Boost Phase # 2 (Select Therapy for Boost Phase)		
☐ **2-Dimension Radiation Therapy:**	✓ Number of ports:	✓ Fractions :
✓ Will a new CT be performed?		☐ Yes ☐ No
☐ **3D Conformal Radiation Therapy:**	✓ Number of ports:	✓ Fractions :
✓ Will a new CT be performed?		☐ Yes ☐ No
☐ **Intensity Modulated Radiation Therapy:**	✓ Number of ports/arcs:	✓ Fractions :
✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Compensator-Based ☐ Helical ☐ Arc Therapy ☐ Other		
✓ Will a new CT be performed?		☐ Yes ☐ No
☐ **Other**	✓ Number of ports:	✓ Fractions :
✓ What is the other type of boost for the first boost treatment?		
☐ **Guidance (IGRT) Technique:** ☐ None ☐ CT Guidance ☐ Stereoscopic with fiducial markers ☐ Other		

Special Services – Please note if you are faxing additional information
☐ **Special Dosimetry (CPT® 77331)** Provide requested quantity and the rationale for performing the service.
☐ **Special Physics Consultation (CPT® 77370)** Provide the rationale for performing the service.
☐ **Special Treatment Procedure (CPT® 77470)** Provide the rationale for performing the service.