



## Rectal 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](http://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                                                                                                                                                                                                                                 |                                                           |                                                                                                                                                                                                                            |                                                              |
| <input checked="" type="checkbox"/> <b>Treatment Intent :</b> <input type="checkbox"/> Pre Operative <input type="checkbox"/> Post Operative- Adjuvant <input type="checkbox"/> Primary Therapy- No Surgery <input type="checkbox"/> Palliative              |                                                           |                                                                                                                                                                                                                            |                                                              |
| <b>T Stage:</b>                                                                                                                                                                                                                                              | <b>N Stage:</b>                                           | <input checked="" type="checkbox"/> <b>If palliative, what is the reason for radiation therapy? (e.g. bleeding, pain, etc.)</b>                                                                                            |                                                              |
| <input type="checkbox"/> TX                                                                                                                                                                                                                                  | <input type="checkbox"/> NX                               | <input checked="" type="checkbox"/> <b>Margin Status: (Post Operative Only)</b> <input type="checkbox"/> Negative <input type="checkbox"/> Close <input type="checkbox"/> Positive <input type="checkbox"/> Not Applicable |                                                              |
| <input type="checkbox"/> T0                                                                                                                                                                                                                                  | <input type="checkbox"/> N0                               | <input checked="" type="checkbox"/> <b>Are you treating a recurrent tumor:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                    |                                                              |
| <input type="checkbox"/> Tis                                                                                                                                                                                                                                 | <input type="checkbox"/> N1                               | <input checked="" type="checkbox"/> <b>Is chemotherapy planned :</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                              |                                                              |
| <input type="checkbox"/> T1                                                                                                                                                                                                                                  | <input type="checkbox"/> N2                               |                                                                                                                                                                                                                            |                                                              |
| <input type="checkbox"/> T2                                                                                                                                                                                                                                  | <b>Does patient have distant metastasis (M1)?</b>         |                                                                                                                                                                                                                            |                                                              |
| <input type="checkbox"/> T3                                                                                                                                                                                                                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |                                                                                                                                                                                                                            |                                                              |
| <input type="checkbox"/> T4                                                                                                                                                                                                                                  |                                                           |                                                                                                                                                                                                                            |                                                              |
| Treatment Planning Information                                                                                                                                                                                                                               |                                                           |                                                                                                                                                                                                                            |                                                              |
| 1. Initial Treatment Phase (Select Therapy for Initial Phase of Treatment)                                                                                                                                                                                   |                                                           |                                                                                                                                                                                                                            |                                                              |
| <input type="checkbox"/> <b>2-Dimension Radiation Therapy:</b>                                                                                                                                                                                               | <input checked="" type="checkbox"/> Number of ports:      | <input checked="" type="checkbox"/> Fractions :                                                                                                                                                                            | <input checked="" type="checkbox"/> Total Course Dose (Gy) : |
| <input checked="" type="checkbox"/> Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined?                                                                                      |                                                           |                                                                                                                                                                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| <input type="checkbox"/> <b>3D Conformal Radiation Therapy:</b>                                                                                                                                                                                              | <input checked="" type="checkbox"/> Number of ports:      | <input checked="" type="checkbox"/> Fractions :                                                                                                                                                                            | <input checked="" type="checkbox"/> Total Course Dose (Gy) : |
| <input checked="" type="checkbox"/> Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined?                                                                                      |                                                           |                                                                                                                                                                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| <input type="checkbox"/> <b>High Dose Rate (HDR) Brachytherapy: (HDR)</b>                                                                                                                                                                                    |                                                           |                                                                                                                                                                                                                            | <input checked="" type="checkbox"/> Fractions:               |
| <input type="checkbox"/> <b>Intensity Modulated Radiation:</b>                                                                                                                                                                                               | <input checked="" type="checkbox"/> Number of ports/arcs: | <input checked="" type="checkbox"/> Fractions :                                                                                                                                                                            | <input checked="" type="checkbox"/> Total Course Dose (Gy) : |
| <input checked="" type="checkbox"/> Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined?                                                                                      |                                                           |                                                                                                                                                                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| <input checked="" type="checkbox"/> Which technique will be used? <input type="checkbox"/> Linac Multi-Angle <input type="checkbox"/> Compensator-Based <input type="checkbox"/> Helical <input type="checkbox"/> Arc Therapy <input type="checkbox"/> Other |                                                           |                                                                                                                                                                                                                            |                                                              |
| <input type="checkbox"/> <b>Image Guidance (IGRT) Technique:</b> <input type="checkbox"/> None <input type="checkbox"/> CT Guidance <input type="checkbox"/> Stereoscopic with fiducial markers <input type="checkbox"/> Other                               |                                                           |                                                                                                                                                                                                                            |                                                              |

*Note: Cancers of the anal canal are not subject to preauthorization; however, treatment sites including both the anal canal as well as the rectum are subject to preauthorization. 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)                                                                                                                                                                            |                         |              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------|
| <input type="checkbox"/> <b>2-Dimension Radiation Therapy:</b>                                                                                                                                                                 | ✓ Number of ports:      | ✓ Fractions: |
| <input type="checkbox"/> <b>3D Conformal Radiation Therapy:</b>                                                                                                                                                                | ✓ Number of ports:      | ✓ Fractions: |
| <input type="checkbox"/> <b>Intensity Modulated Radiation Therapy</b>                                                                                                                                                          | ✓ Number of ports/arcs: | ✓ Fractions: |
| <input type="checkbox"/> <b>High Dose Rate (HDR) Brachytherapy:</b>                                                                                                                                                            | ✓ Fractions:            |              |
| <input type="checkbox"/> <b>Image Guidance (IGRT) Technique:</b> <input type="checkbox"/> None <input type="checkbox"/> CT Guidance <input type="checkbox"/> Stereoscopic with fiducial markers <input type="checkbox"/> Other |                         |              |
| 3. Boost Phase # 2 (Select Therapy for Boost Phase)                                                                                                                                                                            |                         |              |
| <input type="checkbox"/> <b>2-Dimension Radiation Therapy:</b>                                                                                                                                                                 | ✓ Number of ports:      | ✓ Fractions: |
| <input type="checkbox"/> <b>3D Conformal Radiation Therapy:</b>                                                                                                                                                                | ✓ Number of ports:      | ✓ Fractions: |
| <input type="checkbox"/> <b>Intensity Modulated Radiation Therapy</b>                                                                                                                                                          | ✓ Number of ports/arcs: | ✓ Fractions: |
| <input type="checkbox"/> <b>High Dose Rate (HDR) Brachytherapy:</b>                                                                                                                                                            | ✓ Fractions:            |              |
| <input type="checkbox"/> <b>Image Guidance (IGRT) Technique:</b> <input type="checkbox"/> None <input type="checkbox"/> CT Guidance <input type="checkbox"/> Stereoscopic with fiducial markers <input type="checkbox"/> Other |                         |              |

| Special Services – Please note if you are faxing additional information                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Special Dosimetry (CPT® 77331)</b> Provide requested quantity and the rationale for performing the service. |
| <input type="checkbox"/> <b>Special Physics Consultation (CPT® 77370)</b> Provide the rationale for performing the service.             |
| <input type="checkbox"/> <b>Special Treatment Procedure (CPT® 77470)</b> Provide the rationale for performing the service.              |