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

<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></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 ____________
  - Is this a new diagnosis of Brain Metastasis? [ ] Yes [ ] No [ ] Unknown
  - What is the location of the brain metastasis? ____________
  - 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

- 2-Dimension [ ] 3D Conformal [ ] IMRT [ ] SRS/SBRT [ ] Proton
- HDR Brachytherapy [ ] LDR Brachytherapy [ ] Other ____________

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

**Boost Phase 1 – Select Therapy**

- **2-Dimension**
- **3D Conformal**
- **IMRT**
- **SRS/SBRT**
- **Proton**
- **Electron**
- **HDR Brachy**
- **LDR Brachy**
- **Other**

**Fractions:** ______

**IMRT ONLY:**
- [ ] 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:**
- [ ] Robotic Linac Multi-Angle
- [ ] Robotic - Tomotherapy
- [ ] Robotic - CyberKnife
- [ ] Non-Robotic - Linac Multi-Angle
- [ ] Non-Robotic - Tomotherapy
- [ ] Non-Robotic - Gamma
- [ ] 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**

- **2-Dimension**
- **3D Conformal**
- **IMRT**
- **SRS/SBRT**
- **Proton**
- **Electron**
- **HDR Brachy**
- **LDR Brachy**
- **Other**

**Fractions:** ______

**IMRT ONLY:**
- [ ] 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:**
- [ ] Robotic Linac Multi-Angle
- [ ] Robotic - Tomotherapy
- [ ] Robotic - CyberKnife
- [ ] Non-Robotic - Linac Multi-Angle
- [ ] Non-Robotic - Tomotherapy
- [ ] Non-Robotic - Gamma
- [ ] 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