Radiation Therapy Other Cancer Checklist

Evolent (formerly National Imaging Associates, Inc.) has provided this checklist to help you in gathering the information needed to request a medical necessity review. Please complete this form and include any applicable clinical documentation (i.e., comparison plan, radiation therapy consultation, imaging results etc.) prior to submitting the case on www.radmd.com. As an alternative, you may also contact our Evolent Call Center.

Other Cancer checklist used for but not limited to diagnosis of: Bladder, Esophagus, Hepatocellular (HCC) Liver Primary, Leukemia, Multiple Myeloma (Plasmacytoma, Active or Smoldering), Mycosis Fungoides, Sarcoma, Thymoma, Thyroid, Trachea, Urethra Cancer, Vaginal, and Vulvar Cancer.

Please note new case requests may not be started by fax.

General Information

Patient Name:
Date of Birth:
Health Plan and Member ID:
Treatment Planning Start Date (i.e., Initial Simulation):
Treatment Start Date:

Clinical Information

ICD-10 Code(s):
What is the treatment site? **Each treatment site requires a separate authorization.**
What is Treatment Intent? Curative/ Palliative
What is the treatment prescription dose for the course of treatment?
What is the **radiation therapy** treatment start date?
Does the member have distant metastases (stage VI or M1) (i.e., disease spread to bone, liver, lung, brain)?
Will all radiation treatment be done at the same facility? YES ☐ NO ☐
History of prior radiation therapy? YES ☐ NO ☐ *If yes, provide details of prior site & total dose along with completion date*:
What is the DOSE that will be used for each phase of treatment? **Phase 1** **Phase 2** **Phase 3**

PLEASE INDICATE THE NUMBER OF FRACTIONS FOR EACH PHASE BELOW

Phase 1	Phase 2 (Boost)	Phase 3	Treatment
			Superficial / Orthovoltage
			2D Radiation Therapy
			3D Radiation Therapy

			Electron Beam Therapy
			Intensity Modulated Radiation Therapy (IMRT)
			Proton Beam Therapy
			Stereotactic Radiosurgery & Stereotactic Radiation Therapy (SRS/SRT)
			Stereotactic Body Radiation Therapy (SBRT)
			Gamma Knife YES☐NO☐
			IORT **Machine Name:**
			LDR Brachytherapy
			HDR Brachytherapy

Plan Type: **IMRT**: **3D**: **Plan Type for SBRT/SRS/SRT and Proton Beam Therapy**

Site Specific Questions for Other Cancer:

Diagnosis:
Original Tumor resected: Yes No
Treatment Intent: Curative or Palliative

T Stage	**N Stage**
TX	NX
T1	N0
T2	N1
T3	N2
T4	N3
M Stage (M1)	
Location of Distant Metastasis:	

Will Selective Internal Radiation Therapy (SIRT) be used?
SIRT CPT Code: 77778 C2616

Will Total Skin Electron Beam therapy (TSEBT) be used?

Number of ports/angles/fields
Phase 1
Phase 2
Phase 3

Type of Imaging: Port Films ☐ IGRT☐ IGRT Frequency:

Will concurrent (simultaneous) chemotherapy be administered during this course of treatment?
YES ☐ NO ☐ **Chemotherapy name**: Chemo dates:

CPT Code 77370 Special Physics **Rationale (Reason)**
CPT Code 77470 Special Treatment **Rationale (Reason)**
CPT Code 77331 Special Dosimetry **Rationale (Reason)**

Additional comments or details:

Please be ready to submit any results of imaging (ultrasounds, x-rays, MRIs, PET Scans, CTs, DVH's) from the past 3 months and radiation therapy prescription plans in addition to the clinical treatment plan. This will assist in the review process. Failure to provide all relevant documentation may cause a delay.