Endometrial Cancer Radiation Therapy Treatment Plan Checklist
1/1/2015

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></td>
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<tr>
<td>Radiation Oncologist</td>
<td>Breast Surgeon</td>
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<tr>
<td>Radiation Therapy Facility</td>
<td></td>
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<tr>
<td>Treatment Planning Start Date (i.e. Initial Simulation):</td>
<td>Anticipated Treatment Start Date:</td>
<td></td>
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</tbody>
</table>

### Patient Clinical Information

- **Uterus primary site being treated:**
  - Yes
  - No
  - Unknown
- **FIGO Stage:**
  - Stage I
  - Stage IA
  - Stage IB
  - Stage II
  - Stage IIIA
  - Stage IIIB
  - Stage IIIC
  - Stage IV
- **Distant metastasis:**
  - Yes
  - No
  - Unknown
- **Tumor Grade:**
  - Grade I
  - Grade II
  - Grade III
- **Treatment Intent:**
  - Pre-Operative
  - Post-Operative
  - Medically Inoperable/Primary
- **Reason for palliative treatment:**
  - ____________________________
- **Any of the following risk factors present:**
  - Lymphovascular space invasion
  - Lower uterine involvement
  - Patient 60 years old or older

### 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**
  - Fractions: ______
- **3D Conformal**
  - Number of ports/arcs/fields: ______
- **IMRT**
  - Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined?
    - Yes
    - No
  - IMRT Only
    - Which technique will be used?
      - Linac Multi-Angle
      - Compensator-Based
      - Helical
      - Arc Therapy
      - Other
    - Will the IMRT course of therapy be inversely planned?
      - Yes
      - No

**IMRT Note:** IMRT treatment requests will 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.

- **High Dose Rate (HDR) Brachytherapy**
  - Fractions: ______
  - Will a tumor volume and at least one critical structure be contoured?
    - Yes
    - No
  - HDR Image Guidance Technique:
    - None
    - CT Guidance
    - X-ray films
    - Ultrasound

- **Low Dose Rate (LDR) Brachytherapy**
  - Fractions: ______
  - Will a tumor volume and at least one critical structure be contoured?
    - Yes
    - No

- **IGRT Technique**
  - None (select none for port films)
  - CT Guidance (Conebeam CT)
  - Stereoscopic Guidance (kV or mV with fiducial markers)
  - At what frequency will the IGRT be performed?
    - Daily
    - 1 time per week
    - Other ____________________________

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### Boost Phase 1 – Select Therapy

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</tr>
<tr>
<td>IMRT</td>
<td>✓ Will a new CT be performed? Yes ☐ No ☐ NA</td>
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**IMRT Only**
- Which technique will be used? ☐ Linac Multi-Angle ☐ Compensator-Based ☐ Helical ☐ Arc Therapy ☐ Other

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<tr>
<th>IGRT Technique</th>
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<td>None (select none for port films)</td>
<td>CT Guidance</td>
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</table>
- At what frequency will the IGRT be performed? Daily ☐ 1 time per week ☐ Other ____________

| High Dose Rate (HDR) | ✓ Fractions: _____ |
| Low Dose Rate (LDR)  | ✓ Image Guidance Technique: None ☐ CT Guidance ☐ Ultrasound ☐ X-ray films |

### 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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- At what frequency will the IGRT be performed? Daily ☐ 1 time per week ☐ Other ____________

| High Dose Rate (HDR) | ✓ Fractions: _____ |
| Low Dose Rate (LDR)  | ✓ Image Guidance Technique: None ☐ CT Guidance ☐ Ultrasound ☐ X-ray films |

**IMRT Note:** IMRT treatment requests will 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.

### 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.