Head and Neck 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

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<th>Patient Name:</th>
<th>DOB:</th>
<th>Health Plan ID:</th>
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<tr>
<th>Radiation Oncologist:</th>
<th>Breast Surgeon:</th>
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<th>Radiation Therapy Facility:</th>
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<tr>
<th>Treatment Planning Start Date (i.e. Initial Simulation):</th>
<th>Anticipated Treatment Start Date:</th>
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### Patient Clinical Information

**Primary tumor site being treated:**
- [ ] Oral Cavity
- [ ] Oropharynx
- [ ] Hypopharynx
- [ ] Nasopharynx
- [ ] Glottic Larynx
- [ ] Supraglottic Larynx
- [ ] Paranasal Sinus
- [ ] Other

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**Positive margins:**
- [ ] Yes
- [ ] No
- [ ] Unknown

**Treatment intent:**
- [ ] Curative
- [ ] Palliative
- [ ] Unknown

**Reason for palliative treatment:**
- [ ]

**Treatment timing:**
- Pre-operative
- Post-operative
- Definitive
- Recurrence

**Adverse risk factors:**
- [ ] Positive node
- [ ] pT3 or pT4
- [ ] Perineural invasion
- Vascular tumor embolism
- Other

**List all post-operative risk factors:**
- [ ]

### 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
- [ ] Proton

**Which technique will be used?**
- [ ] Linac Multi-Angle
- [ ] Compensator-Based
- [ ] Helical
- [ ] Arc Therapy
- [ ] Other

**Will any of the following take place during the simulation:**
- Custom device created, contrast utilized or custom blocking determined?
- [ ] Yes
- [ ] No

**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

V1 01/1/2015
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1/1/2015

**Boost Phase 1 – Select Therapy**

- **2-Dimension**
  - ✔ Fractions: ______

- **3D Conformal**
  - ✔ Number of ports/arc/fields: ______

- **IMRT**
  - ✔ Will a new CT be performed? | Yes | No | NA

  **IMRT Only**
  - ✔ Which technique will be used? | Linac Multi-Angle | Compensator-Based | Helical | Arc Therapy | Other

  **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 ______________

**High Dose Rate (HDR)**

- ✔ Fractions: ______

**Low Dose Rate (LDR)**

- ✔ Image Guidance Technique: | None | CT Guidance | Ultrasound | X-ray films

**Boost Phase 2 – Select Therapy**

- **2-Dimension**
  - ✔ Fractions: ______

- **3D Conformal**
  - ✔ Number of ports/arc/fields: ______

- **IMRT**
  - ✔ Will a new CT be performed? | Yes | No | NA

  **IMRT Only**
  - ✔ Which technique will be used? | Linac Multi-Angle | Compensator-Based | Helical | Arc Therapy | Other

  **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 ______________

**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.