Non-Hodgkin’s Lymphoma 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 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>Breast Surgeon:</td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy Facility:</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

- **Location of the tumor being treated:** ______________________________________
- **Treatment Intent:** [ ] Curative   [ ] Palliative   [ ] Unknown
- **Stage:** [ ] Stage I  [ ] Stage II  [ ] Stage III  [ ] Stage IV
- **Type of lymphoma:** [ ] Follicular  [ ] Mantle Cell  [ ] MALT  [ ] Diffuse Large B Cell  [ ] Burkitt’s  [ ] Other
- **Bulky disease:** [ ] Yes  [ ] No  [ ] Unknown
- **Receive chemotherapy or chemotherapy planned:** [ ] Yes  [ ] No  [ ] 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**
  - 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
  - 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.

- **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 _______________________

Boost Phase 1 – Select Therapy

V1 01/1/2015
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| 2-Dimensional | ✓ Fractions: _____ |
| 3D Conformal | ✓ Number of ports/arcs/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 |

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.

| 2-Dimensional | ✓ Fractions: _____ |
| 3D Conformal | ✓ Number of ports/arcs/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 ________________ |

Boost Phase 2 – Select Therapy

| 2-Dimensional | ✓ Fractions: _____ |
| 3D Conformal | ✓ Number of ports/arcs/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 ________________ |

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.