Non-Small Cell Lung 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 or call the NIA Call Center toll free number. Please do not fax the checklist to NIA.

<table>
<thead>
<tr>
<th>General Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name :</td>
</tr>
<tr>
<td>DOB:</td>
</tr>
<tr>
<td>Health Plan ID :</td>
</tr>
<tr>
<td>Radiation Oncologist:</td>
</tr>
<tr>
<td>Radiation Therapy Facility :</td>
</tr>
<tr>
<td>Treatment Planning Start Date (i.e. Initial Simulation) :</td>
</tr>
<tr>
<td>Anticipated Treatment Start Date :</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Clinical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Intent :</td>
</tr>
<tr>
<td>Pre- Operative</td>
</tr>
<tr>
<td>Primary Therapy- Inoperable</td>
</tr>
<tr>
<td>T Stage:</td>
</tr>
<tr>
<td>TX</td>
</tr>
<tr>
<td>T0</td>
</tr>
<tr>
<td>TiS</td>
</tr>
<tr>
<td>T1</td>
</tr>
<tr>
<td>T2</td>
</tr>
<tr>
<td>T3</td>
</tr>
<tr>
<td>T4</td>
</tr>
<tr>
<td>N Stage:</td>
</tr>
<tr>
<td>N0</td>
</tr>
<tr>
<td>N1</td>
</tr>
<tr>
<td>N2</td>
</tr>
<tr>
<td>N3</td>
</tr>
<tr>
<td>Does patient have distant metastasis (M1)?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>If palliative, what is the reason for radiation therapy? (e.g. airway obstruction, hemoptysis pain, etc.)</td>
</tr>
<tr>
<td>Margin Status (Post Operative Only): Negative</td>
</tr>
<tr>
<td>Is there extracapsular nodal extension? Yes</td>
</tr>
<tr>
<td>Is chemotherapy planned? Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Planning Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the prescription radiation dose for the ENTIRE course of external beam treatment? Gy</td>
</tr>
</tbody>
</table>

**Initial Treatment Phase - Select Therapy**

<table>
<thead>
<tr>
<th>2-Dimension</th>
<th>Fractions : ______</th>
</tr>
</thead>
<tbody>
<tr>
<td>3D Conformal</td>
<td>Number of ports/arcs/fields: ______</td>
</tr>
<tr>
<td>IMRT</td>
<td>Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined? Yes</td>
</tr>
<tr>
<td>IMRT Only</td>
<td>Which technique will be used? Linac Multi-Angle</td>
</tr>
<tr>
<td>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 and tissue constraints and target goals of the plan. Field in field or forward planning is not considered IMRT.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SBRT</th>
<th>Number of ports/arcs/fields: ______</th>
<th>Fractions : ______</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Dose Rate (HDR) Brachytherapy:</td>
<td>Fractions: ______</td>
<td></td>
</tr>
<tr>
<td>Image Guidance (IGRT)</td>
<td>Technique:</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>CT Guidance</td>
<td>Stereoscopic</td>
</tr>
</tbody>
</table>

| Technique: |
| At what frequency will the IGRT be performed? Daily | 1 time per week | Other |
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### Boost Phase 1 – Select Therapy

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>2-Dimension</td>
<td>Fractions: _____</td>
</tr>
<tr>
<td>3D Conformal</td>
<td>Number of ports/arcs/fields: _____</td>
</tr>
<tr>
<td>IMRT</td>
<td>Will a new CT be performed?  Yes  No</td>
</tr>
</tbody>
</table>

- IMRT Only
  - Which technique will be used?  Linac Multi-Angle  Compensator-Based  Helical  Arc Therapy  Other
  - Will techniques to account for respiratory motion be performed?  Yes  No

- Image Guidance (IGRT) Technique:
  - None  (select none for port films)
  - CT Guidance  (Conebeam CT)
  - Stereoscopic Guidance (kV or mV)

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

### Boost Phase 2 – Select Therapy

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-Dimension</td>
<td>Fractions: _____</td>
</tr>
<tr>
<td>3D Conformal</td>
<td>Number of ports/arcs/fields: _____</td>
</tr>
<tr>
<td>IMRT</td>
<td>Will a new CT be performed?  Yes  No</td>
</tr>
</tbody>
</table>

- IMRT Only
  - Which technique will be used?  Linac Multi-Angle  Compensator-Based  Helical  Arc Therapy  Other
  - Will techniques to account for respiratory motion be performed?  Yes  No

- Image Guidance (IGRT) Technique:
  - None  (select none for port films)
  - CT Guidance  (Conebeam CT)
  - Stereoscopic Guidance (kV or mV)

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

**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 and tissue constraints and target goals of the plan. Field in field or forward planning is not considered IMRT.

### 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.