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>Radiation Therapy Facility</td>
<td></td>
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<td></td>
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<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>
</tr>
<tr>
<td></td>
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</tbody>
</table>

### Patient Clinical Information

- **Treatment Intent:**
  - ☐ Pre Operative
  - ☐ Post Operative- Adjuvant
  - ☐ Primary Therapy- No Surgery
  - ☐ Palliative

- **T Stage:**
  - ☐ TX
  - ☐ T0
  - ☐ Tis
  - ☐ T1
  - ☐ T2
  - ☐ T3
  - ☐ T4

- **N Stage:**
  - ☐ NX
  - ☐ N0
  - ☐ N1
  - ☐ N2

- If palliative, what is the reason for radiation therapy? (e.g. bleeding, pain, etc.)

- Margin Status: (Post Operative Only)
  - ☐ Negative
  - ☐ Close
  - ☐ Positive
  - ☐ Not Applicable

- Are you treating a recurrent tumor: ☐ Yes  ☐ No  ☐ Unknown

- Does patient have distant metastasis (M1)?
  - ☐ Yes  ☐ No

- Is 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
  - ✓ Number of ports/arcs/fields: ____

- ☐ 3D Conformal
  - ✓ Fractions: ____

- ☐ 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

**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.

- ☐ High Dose Rate (HDR) Brachytherapy: (HDR)
  - ✓ Fractions: ____

- ☐ IGRT Technique:
  - ☐ None (select none)
  - ☐ 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

<table>
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<tr>
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**IMRT Only** ✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Compensator-Based ☐ Helical ☐ Arc Therapy ☐ 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.

| High Dose Rate (HDR) Brachytherapy: (HDR) | ✓ Fractions: ______ |

**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

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**IMRT Only** ✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Compensator-Based ☐ Helical ☐ Arc Therapy ☐ 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.

| High Dose Rate (HDR) Brachytherapy: (HDR) | ✓ Fractions: ______ |

**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.