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></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Radiation Oncologist</th>
<th>Breast Surgeon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Radiation Therapy Facility</th>
<th>Treatment Planning Start Date (i.e. Initial Simulation)</th>
<th>Anticipated Treatment Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patient Clinical Information

- **Site of primary cancer:**
  - Breast
  - Prostate
  - Lung
  - Other
  - Unknown

- **How many sites are being treated:**
  - Single Site
  - Two or More Sites
  - Unknown

- **Location of the bone mets being treated:**
  - Spine
  - Femur
  - Pelvis
  - Rib
  - Humerus
  - Shoulder
  - Skull
  - Other

- **Reason for treatment (e.g. pain, spinal cord compression, etc):**
  - ____________________________

- **List other sites with metastatic disease:**
  - __________________________________________________

- **What is the patient’s performance status? (ECOG Scale)**
  - 0 – Fully active, able to carry on all pre-disease performance without restriction
  - 1 – Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
  - 2 – Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
  - 3 – Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
  - 4 – Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair

- **Has patient had prior radiation for bone metastasis:**
  - 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

<table>
<thead>
<tr>
<th>2-Dimension</th>
<th>3D Conformal</th>
<th>IMRT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Fractions:**
  - ______

- **Number of ports/arcs/fields:**
  - ______

- **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

<table>
<thead>
<tr>
<th>Stereotactic Body RT (SBRT)</th>
<th>Fractions:</th>
<th>Number of ports/arcs/fields:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Which technique will be used?**
  - Robotic - Linac Multi-Angle
  - Robotic - Tomotherapy
  - Robotic - Cyberknife
  - Non-Robotic – Linac Multi-Angle
  - Non-Robotic - Tomotherapy
  - Non-Robotic – Gamma Knife

<table>
<thead>
<tr>
<th>IGRT Technique</th>
<th>None (select none for port films)</th>
<th>CT Guidance (Conebeam CT)</th>
<th>Stereoscopic Guidance (kV or mV with fiducial markers)</th>
</tr>
</thead>
</table>

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