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>
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<tr>
<th>Radiation Oncologist</th>
<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

- **Treatment Intent**: □ Pre Operative □ Post Operative- Adjvant □ 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**
  - 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

#### 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 using fiducial markers)

  - At what frequency will the IGRT be performed? □ Daily □ 1 time per week □ Other ____________________
**Colon Cancer Radiation Therapy Treatment Plan Checklist**

1/1/2015

### Boost Phase 1 – 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 |
| **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.*

### Boost Phase 2 – 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 |
| **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 using 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.