Rectal Cancer Radiation Therapy Treatment Plan Checklist

9/01/2012

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

Patient Name :	DOB:	Health Plan ID :
Radiation Oncologist :	Radiation Therapy Facility :	
Treatment Planning Start Date (i.e. Initial Simulation) :		Anticipated Treatment Start Date :

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

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

✓ 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

✓ 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**

☐ **3D Conformal**

☐ **IMRT**

✓ Number of ports/arcs/fields: _____

✓ Fractions: _____

✓ 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 77014) ☐ Stereoscopic Guidance (kV or mV with fiducial markers 77421)

✓ At what frequency will the IGRT be performed? ☐ Daily ☐ 1 time per week ☐ Other _____

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Boost Phase 1 – 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

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✓ At what frequency will the IGRT be performed? ☐ Daily ☐ 1 time per week ☐ Other _____

Boost Phase 2 – 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

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✓ 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.