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

- **3D Conformal**
  - Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined?
    - Yes
    - No

- **IMRT**
  - 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 77014)
  - Stereoscopic Guidance (kV or mV with fiducial markers 77421)

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

*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 _____________________

### 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

*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 _____________________

### 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.