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>Radiation Oncologist :</td>
<td>Radiation Therapy Facility :</td>
<td></td>
</tr>
<tr>
<td>Treatment Planning Start Date (i.e. Initial Simulation) :</td>
<td>Anticipated Treatment Start Date :</td>
<td></td>
</tr>
</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**
  - [ ] 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 (77014 Conebeam CT)
  - [ ] Stereoscopic Guidance (77421 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**

9/1/2012

### Boost Phase 1 – Select Therapy

<table>
<thead>
<tr>
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<tr>
<td>IMRT</td>
<td>✓ Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined? □ Yes □ No</td>
</tr>
</tbody>
</table>

**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 (77014 Conebeam CT) | Stereoscopic Guidance (77421 kV or mV using 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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<thead>
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<th>2-Dimension</th>
<th>✓ Fractions: _____</th>
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</table>

**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 (77014 Conebeam CT) | Stereoscopic Guidance (77421 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.