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>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

<table>
<thead>
<tr>
<th>T Stage:</th>
<th>N Stage:</th>
<th>If palliative, what is the reason for radiation therapy? (e.g. bleeding, pain, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>NX</td>
<td></td>
</tr>
<tr>
<td>T0</td>
<td>N0</td>
<td></td>
</tr>
<tr>
<td>Tis</td>
<td>N1</td>
<td></td>
</tr>
<tr>
<td>T1</td>
<td>N2</td>
<td></td>
</tr>
<tr>
<td>T2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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  [ ] SRS/SBRT  [ ] Proton
- [ ] HDR Brachytherapy  [ ] LDR Brachytherapy  [ ] Other _______________

Fractions: _______

**IMRT ONLY:**

Which technique will be used? [ ] Linac Multi-Angle  [ ] Compensator-Based  [ ] Helical  [ ] Arc Therapy  [ ] Other

**Note:** IMRT treatment requests may 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. Field in field or forward planning is not considered IMRT.

#### SRS/SBRT ONLY:

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
- [ ] Unknown
- [ ] Other _________________________
Rectal Cancer Radiation Therapy
Treatment Plan Checklist

### Boost Phase 1 – Select Therapy

<table>
<thead>
<tr>
<th>2-Dimension</th>
<th>3D Conformal</th>
<th>IMRT</th>
<th>SRS/SBRT</th>
<th>Proton</th>
<th>Electron</th>
<th>HDR Brachy</th>
<th>LDR Brachy</th>
<th>Other</th>
</tr>
</thead>
</table>

Fractions: ______

**IMRT ONLY:**

Which technique will be used? □ Linac Multi-Angle □ Compensator-Based □ Helical □ Arc Therapy □ Other

**Note:** IMRT treatment requests may 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. Field in field or forward planning is not considered IMRT.

**SRS/SBRT ONLY:**

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
□ Unknown □ Other _________________________

**LDR ONLY:**

If any portion of the patient’s radiation oncology treatment will be performed in a facility or hospital other than the facility previously stated, what is the name of that facility? ___________________________________________________________________________________

Which portion of the treatment will be performed at the additional facility? □ NA □ Initial Phase □ Boost Phase

### Boost Phase 2 – Select Therapy

<table>
<thead>
<tr>
<th>2-Dimension</th>
<th>3D Conformal</th>
<th>IMRT</th>
<th>SRS/SBRT</th>
<th>Proton</th>
<th>Electron</th>
<th>HDR Brachy</th>
<th>LDR Brachy</th>
<th>Other</th>
</tr>
</thead>
</table>

Fractions: ______

**IMRT ONLY:**

Which technique will be used? □ Linac Multi-Angle □ Compensator-Based □ Helical □ Arc Therapy □ Other

**Note:** IMRT treatment requests may 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. Field in field or forward planning is not considered IMRT.

**SRS/SBRT ONLY:**

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
□ Unknown □ Other _________________________

**LDR ONLY:**

If any portion of the patient’s radiation oncology treatment will be performed in a facility or hospital other than the facility previously stated, what is the name of that facility? ___________________________________________________________________________________

Which portion of the treatment will be performed at the additional facility? □ NA □ Initial Phase □ Boost Phase