

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

T Stage: <input type="checkbox"/> TX <input type="checkbox"/> T0 <input type="checkbox"/> Tis <input type="checkbox"/> T1 <input type="checkbox"/> T2 <input type="checkbox"/> T3 <input type="checkbox"/> T4	N Stage: <input type="checkbox"/> NX <input type="checkbox"/> N0 <input type="checkbox"/> N1 <input type="checkbox"/> N2 <input type="checkbox"/> N3 Does patient have distant metastasis (M1)? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Cancer Stage: <input type="checkbox"/> Limited <input type="checkbox"/> Extensive <input checked="" type="checkbox"/> Treatment Intent : <input type="checkbox"/> Curative <input type="checkbox"/> Palliative <input checked="" type="checkbox"/> If palliative, what is the reason for radiation therapy? (e.g. airway obstruction, hemoptysis pain, etc.) <input checked="" type="checkbox"/> Is chemotherapy planned : <input type="checkbox"/> Yes <input type="checkbox"/> No
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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?

<input type="checkbox"/> Robotic Linac Multi-Angle	<input type="checkbox"/> Robotic - Tomotherapy	<input type="checkbox"/> Robotic - CyberKnife
<input type="checkbox"/> Non-Robotic - Linac Multi-Angle	<input type="checkbox"/> Non-Robotic - Tomotherapy	<input type="checkbox"/> Non-Robotic - Gamma Knife
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____	

Boost Phase 1 – Select Therapy

- | | | | | |
|--------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|---------------------------------|
| <input type="checkbox"/> 2-Dimension | <input type="checkbox"/> 3D Conformal | <input type="checkbox"/> IMRT | <input type="checkbox"/> SRS/SBRT | <input type="checkbox"/> Proton |
| <input type="checkbox"/> Electron | <input type="checkbox"/> HDR Brachy | <input type="checkbox"/> LDR Brachy | <input type="checkbox"/> 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?

<input type="checkbox"/> Robotic Linac Multi-Angle	<input type="checkbox"/> Robotic - Tomotherapy	<input type="checkbox"/> Robotic - CyberKnife
<input type="checkbox"/> Non-Robotic - Linac Multi-Angle	<input type="checkbox"/> Non-Robotic - Tomotherapy	<input type="checkbox"/> Non-Robotic - Gamma Knife
<input type="checkbox"/> Unknown	<input type="checkbox"/> 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

- | | | | | |
|--------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|---------------------------------|
| <input type="checkbox"/> 2-Dimension | <input type="checkbox"/> 3D Conformal | <input type="checkbox"/> IMRT | <input type="checkbox"/> SRS/SBRT | <input type="checkbox"/> Proton |
| <input type="checkbox"/> Electron | <input type="checkbox"/> HDR Brachy | <input type="checkbox"/> LDR Brachy | <input type="checkbox"/> 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?

<input type="checkbox"/> Robotic Linac Multi-Angle	<input type="checkbox"/> Robotic - Tomotherapy	<input type="checkbox"/> Robotic - CyberKnife
<input type="checkbox"/> Non-Robotic - Linac Multi-Angle	<input type="checkbox"/> Non-Robotic - Tomotherapy	<input type="checkbox"/> Non-Robotic - Gamma Knife
<input type="checkbox"/> Unknown	<input type="checkbox"/> 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