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>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Radiation Oncologist</th>
<th>Breast Surgeon</th>
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<table>
<thead>
<tr>
<th>Radiation Therapy Facility</th>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Treatment Planning Start Date (i.e. Initial Simulation)</th>
<th>Anticipated Treatment Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patient Clinical Information

- **T Stage:**
  - TX
  - T0
  - Tis
  - T1
  - T2
  - T3
  - T4

- **N Stage:**
  - NX
  - N0
  - N1
  - N2

- **Treatment Intent:**
  - Curative
  - Palliative

- **Reason for palliative treatment:** [ ]

- **Treatment Timing:**
  - Primary
  - Pre-Operative
  - Post-Operative

- **Margin Status:**
  - Positive
  - Negative
  - Close
  - Not Applicable

- **Is this a recurrent tumor?**
  - Yes
  - No

- **Is chemotherapy planned?**
  - Yes
  - No

- **Does patient have distant metastasis (M1)?**
  - Yes
  - No

### 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**

**Fractons:**

**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
### Boost Phase 1 – Select Therapy

<table>
<thead>
<tr>
<th>2-Dimension</th>
<th>3D Conformal</th>
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</thead>
<tbody>
<tr>
<td>Electron</td>
<td>HDR Brachy</td>
<td>LDR Brachy</td>
<td>Other</td>
<td></td>
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Fractions: ______

**IMRT ONLY:**

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

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**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>
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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