NIA Magellan 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 Magellan Call Center toll free number.

Please **do not fax** the checklist to NIA Magellan.

### 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></td>
<td>Breast Surgeon:</td>
</tr>
<tr>
<td>Radiation Therapy Facility:</td>
<td></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:**
  - ☑ Curative
  - ☐ Palliative

- **Treatment Timing:**
  - ☑ Post-Lumpectomy
  - ☑ Post-Mastectomy
  - ☐ Other

- **T Stage:**
  - ☑ TX
  - ☑ Tis (DCIS)
  - ☑ Tis (LCIS)
  - ☑ T1
  - ☑ T2
  - ☑ T3
  - ☑ T4

- **N Stage:**
  - ☑ NX
  - ☑ N0
  - ☑ N1
  - ☑ N2
  - ☑ N3

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

- **Breast Being Treating:**
  - ☑ Right Breast
  - ☑ Left Breast

- **Area Being Treated:**
  - ☑ Whole Breast
  - ☑ Partial Breast
  - ☑ Chest Wall

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

- **Lymph Node Involvement:**
  - ☑ None
  - ☑ Regional
  - ☑ Sentinel
  - ☑ Both Regional/Sentinel

- **Margin Status:**
  - ☑ Negative
  - ☑ Close
  - ☑ Positive

- **Is nodal radiation planned?**
  - ☑ Yes
  - ☑ No

- **Has patient received pre-operative chemotherapy:**
  - ☑ 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 _______________

**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 _______________________
## Breast Cancer Radiation Therapy
### Treatment Plan Checklist

### Boost Phase 1 – Select Therapy

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<td>HDR Brachy</td>
<td>LDR Brachy</td>
<td>Other ________________</td>
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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

### Boost Phase 2 – Select Therapy

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### IMRT ONLY:
Which technique will be used?  
- [ ] Linac Multi-Angle  
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- [ ] 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  
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- [ ] 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