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></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

- **Brain Tumor (Primary)**
  - Type of tumor being treated:
    - Glioma – Low Grade
    - Glioma – High Grade
    - Anaplastic Ependymoma
    - Meningioma – Low Grade
    - Medulloblastoma/Supratentorial PNET
    - Ependymoma – Low Grade
    - Meningioma – High Grade
  - What surgery has been performed:
    - Biopsy Only
    - Subtotal Resection
    - Total Resection
  - Initial or Recurrent Tumor:
    - Initial Brain Tumor
    - Recurrent Brain Tumor
    - Unknown

- **CNS Lymphoma (Primary)**
  - Did patient receive chemotherapy:
    - Yes
    - No
    - Unknown
  - Chemotherapy response:
    - Complete response
    - Partial response
    - No response
    - Unknown
    - Not Applicable
  - What is the patient’s performance status? (ECOG Scale)
    - 0 – Fully active, able to carry on all pre-disease performance without restriction
    - 1 – Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature
    - 2 – Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
    - 3 – Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
    - 4 – Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair

- **Spinal Tumor (Primary)**
  - Is the tumor amenable to surgery:
    - Yes
    - No
    - Unknown
  - Tumor causing intractable pain:
    - Yes
    - No
    - Unknown
  - Tumor causing spinal cord compression:
    - Yes
    - No
    - Unknown

- **Other Primary CNS Tumor**
  - Why is the patient receiving radiation treatment: ________________________________________________________________________________________________
  - What is the treatment intent/timing:
    - Primary
    - Adjuvant radiation therapy
    - Unknown
    - Other
  - Is treatment for initial or recurrent tumor:
    - Initial Tumor
    - Recurrent Tumor
    - Unknown

### Treatment Planning Information

- **What is the prescription radiation dose for the ENTIRE course of external beam treatment?**
  - Gy

### Initial Treatment Phase – Select Therapy

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

Del Only Revised 02/17/2015
### Boost Phase 1 – Select Therapy

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<td>HDR Brachy</td>
<td>LDR Brachy</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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<td>HDR Brachy</td>
<td>LDR Brachy</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