Central Nervous System Primary Cancer Radiation Therapy Treatment Plan Checklist

NIA Magellan℠

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 :	Breast Surgeon :	
Radiation Therapy Facility :		
Treatment Planning Start Date (i.e. Initial Simulation):	Anticipated Treatment Start Date:	

Patient Clinical Information

☐ Brain Tumor (Primary)

✓ Type of tumor being treated: ☐ Glioma – Low Grade ☐ Glioma – High Grade ☐ Ependymoma – Low Grade ☐ Anaplastic Ependymoma ☐ Meningioma – Low Grade ☐ Meningioma – High Grade ☐ Medulloblastoma/Supratentorial PNET ☐ Other ________________

✓ 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

☐ **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 __________________________

Boost Phase 1 – Select Therapy

☐ **2-Dimension** ☐ **3D Conformal** ☐ **IMRT** ☐ **SRS/SBRT** ☐ **Proton**
☐ **Electron** ☐ **HDR Brachy** ☐ **LDR Brachy** ☐ **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 ________________________

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

☐ **2-Dimension** ☐ **3D Conformal** ☐ **IMRT** ☐ **SRS/SBRT** ☐ **Proton**
☐ **Electron** ☐ **HDR Brachy** ☐ **LDR Brachy** ☐ **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
☐ 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