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>
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<tbody>
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<table>
<thead>
<tr>
<th>Radiation Oncologist</th>
<th>Radiation Therapy Facility</th>
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<table>
<thead>
<tr>
<th>Treatment Planning Start Date (i.e. Initial Simulation)</th>
<th>Anticipated Treatment Start Date</th>
</tr>
</thead>
<tbody>
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**Patient Clinical Information**

- **Treatment Intent**
  - Pre Operative
  - Post Operative- Adjuvant
  - Primary Therapy- No Surgery
  - Palliative

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

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

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

- **If palliative, what is the reason for radiation therapy?** (e.g. bleeding, pain, etc.)

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

- **Are you treating a recurrent tumor?**
  - Yes
  - No
  - Unknown

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

- **General Information**

  - **Patient Name:**
  - **DOB:**
  - **Health Plan ID:**

  - **Radiation Oncologist:**
  - **Radiation Therapy Facility:**

  - **Treatment Planning Start Date:**
  - **Anticipated Treatment Start Date:**

**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.

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- 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

### 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 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