NIA Magellan

Head and Neck Cancer Radiation Therapy Treatment Plan Checklist

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

✓ **Primary tumor site being treated:** ☐ Oral Cavity ☐ Oropharynx ☐ Hypopharynx ☐ Nasopharynx ☐ Glottic Larynx ☐ Supraglottic Larynx ☐ Paranasal Sinus ☐ Other

T Stage:
☐ TX
☐ T0
☐ Tis
☐ T1
☐ T2
☐ T3
☐ T4

N Stage:
☐ NX
☐ N0
☐ N1
☐ N2
☐ N3

Does patient have distant metastasis (M1)?
☐ Yes ☐ No

✓ **Positive margins:** ☐ Yes ☐ No ☐ Unknown

✓ **Treatment intent :** ☐ Curative ☐ Palliative ☐ Unknown

✓ **Reason for palliative treatment:** ____________________

✓ **Treatment timing:** ☐ Pre-operative ☐ Post-operative ☐ Definitive ☐ Recurrence

✓ **Adverse risk factors:** ☐ Positive node ☐ pT3 or pT4 ☐ Perineural invasion ☐ Vascular tumor embolism ☐ Other

✓ **List all post-operative risk factors:** ____

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