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](http://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>
<tr>
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<table>
<thead>
<tr>
<th>Radiation Oncologist</th>
<th>Breast Surgeon</th>
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<table>
<thead>
<tr>
<th>Radiation Therapy Facility</th>
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<tbody>
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</table>

<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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</tbody>
</table>

### Patient Clinical Information

- **Primary tumor site being treated:**
  - [ ] Oral Cavity
  - [ ] Oropharynx
  - [ ] Hypopharynx
  - [ ] Nasopharynx
  - [ ] Glottic Larynx
  - [ ] Supraglottic Larynx
  - [ ] Paranasal Sinus
  - [ ] Other

- **T Stage:**
  - [ ] TX
  - [ ] T0
  - [ ] T1
  - [ ] T2
  - [ ] T3
  - [ ] T4

- **N Stage:**
  - [ ] NX
  - [ ] N0
  - [ ] N1
  - [ ] N2
  - [ ] N3

- **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 ________________

<table>
<thead>
<tr>
<th>Fractions:</th>
<th>_____</th>
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</thead>
</table>

### 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

<table>
<thead>
<tr>
<th>2-Dimension</th>
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<th>SRS/SBRT</th>
<th>Proton</th>
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</thead>
<tbody>
<tr>
<td>Electron</td>
<td>HDR Brachy</td>
<td>LDR Brachy</td>
<td>Other ___________</td>
<td></td>
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</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  
- [ ] Non-Robotic - Linac Multi-Angle  
- [ ] Unknown  
- [ ] Other _______________  
- [ ] Robotic - Tomotherapy  
- [ ] Non-Robotic - Tomotherapy  
- [ ] Non-Robotic - Gamma Knife

**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

<table>
<thead>
<tr>
<th>2-Dimension</th>
<th>3D Conformal</th>
<th>IMRT</th>
<th>SRS/SBRT</th>
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<td>HDR Brachy</td>
<td>LDR Brachy</td>
<td>Other ___________</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  
- [ ] Non-Robotic - Linac Multi-Angle  
- [ ] Unknown  
- [ ] Other _______________  
- [ ] Robotic - Tomotherapy  
- [ ] Non-Robotic - Tomotherapy  
- [ ] Non-Robotic - Gamma Knife

**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