

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											
<p>✓ Location of the tumor being treated: _____</p> <p>✓ Number of sites being treated: _____</p> <p>✓ Treated for Lymphocyte Predominant Hodgkin's Lymphoma: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>✓ Treatment timing : <input type="checkbox"/> Definitive <input type="checkbox"/> Adjuvant <input type="checkbox"/> Recurrent/Relapse <input type="checkbox"/> Other _____</p> <p>✓ Treatment Intent : <input type="checkbox"/> Curative <input type="checkbox"/> Palliative <input type="checkbox"/> Unknown</p> <p>✓ Stage : <input type="checkbox"/> Stage I <input type="checkbox"/> Stage IB <input type="checkbox"/> Stage II <input type="checkbox"/> Stage IIB <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV</p> <p>✓ Bulky disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>✓ Receive chemotherapy or chemotherapy planned: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>✓ Previous radiation treatment for Hodgkin's: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>											
Treatment Planning Information											
✓ What is the prescription radiation dose for the <u>ENTIRE</u> course of external beam treatment?		Gy									
Initial Treatment Phase – Select Therapy											
<input type="checkbox"/> 2-Dimension <input type="checkbox"/> 3D Conformal <input type="checkbox"/> IMRT <input type="checkbox"/> SRS/SBRT <input type="checkbox"/> Proton <input type="checkbox"/> HDR Brachytherapy <input type="checkbox"/> LDR Brachytherapy <input type="checkbox"/> Other _____											
Fractions: _____											
<p>IMRT ONLY:</p> <p>Which technique will be used? <input type="checkbox"/> Linac Multi-Angle <input type="checkbox"/> Compensator-Based <input type="checkbox"/> Helical <input type="checkbox"/> Arc Therapy <input type="checkbox"/> Other</p> <p><u>Note:</u> 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.</p>											
<p>SRS/SBRT ONLY:</p> <p>Which technique will be used?</p> <table style="width:100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Robotic Linac Multi-Angle</td> <td style="width: 33%;"><input type="checkbox"/> Robotic - Tomotherapy</td> <td style="width: 33%;"><input type="checkbox"/> Robotic - CyberKnife</td> </tr> <tr> <td><input type="checkbox"/> Non-Robotic - Linac Multi-Angle</td> <td><input type="checkbox"/> Non-Robotic - Tomotherapy</td> <td><input type="checkbox"/> Non-Robotic - Gamma Knife</td> </tr> <tr> <td><input type="checkbox"/> Unknown</td> <td colspan="2"><input type="checkbox"/> Other _____</td> </tr> </table>			<input type="checkbox"/> Robotic Linac Multi-Angle	<input type="checkbox"/> Robotic - Tomotherapy	<input type="checkbox"/> Robotic - CyberKnife	<input type="checkbox"/> Non-Robotic - Linac Multi-Angle	<input type="checkbox"/> Non-Robotic - Tomotherapy	<input type="checkbox"/> Non-Robotic - Gamma Knife	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____	
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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?

<input type="checkbox"/> Robotic Linac Multi-Angle	<input type="checkbox"/> Robotic - Tomotherapy	<input type="checkbox"/> Robotic - CyberKnife
<input type="checkbox"/> Non-Robotic - Linac Multi-Angle	<input type="checkbox"/> Non-Robotic - Tomotherapy	<input type="checkbox"/> Non-Robotic - Gamma Knife
<input type="checkbox"/> Unknown	<input type="checkbox"/> 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?

<input type="checkbox"/> Robotic Linac Multi-Angle	<input type="checkbox"/> Robotic - Tomotherapy	<input type="checkbox"/> Robotic - CyberKnife
<input type="checkbox"/> Non-Robotic - Linac Multi-Angle	<input type="checkbox"/> Non-Robotic - Tomotherapy	<input type="checkbox"/> Non-Robotic - Gamma Knife
<input type="checkbox"/> Unknown	<input type="checkbox"/> 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