NIA Magellan

Non-Small Cell Lung 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 :	Radiation Therapy Facility :	
Treatment Planning Start Date (i.e. Initial Simulation) :	Anticipated Treatment Start Date :	

Patient Clinical Information

✓ **Treatment Intent :**
- ☐ Pre- Operative
- ☐ Post-Operative – Adjuvant
- ☐ Primary Therapy- Inoperable
- ☐ Palliative

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

N Stage:
☐ NX
☐ N0 ☐ N2
☐ N1 ☐ N3

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

✓ If palliative, what is the reason for radiation therapy? (e.g. airway obstruction, hemoptysis pain, etc.)

✓ Margin Status (Post Operative Only): ☐ Negative ☐ Close ☐ Positive ☐ N/A

✓ Is there extracapsular nodal extension? ☐ Yes ☐ No

✓ Is chemotherapy planned? ☐ Yes ☐ No

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