Central Nervous System (CNS) Metastatic 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

☐ Brain Metastasis

- ✓ **Site of primary cancer:** ☐ Bladder ☐ Breast ☐ Colorectal ☐ Head/Neck ☐ Lung ☐ Prostate ☐ Other _____
- ✓ **Is this a new diagnosis of Brain Metastasis?** ☐ Yes ☐ No ☐ Unknown
- ✓ **What is the location of the brain metastasis?** _____
- ✓ **Active cancer in another organ system:** ☐ Yes ☐ No ☐ Unknown
- ✓ **Receiving radiation treatment to another site:** ☐ Yes ☐ No ☐ Unknown
- ✓ **If systemic disease, is it controlled:** ☐ Yes ☐ No ☐ Unknown
- ✓ **How many lesions are present:** _____ **Size of lesions in cm:** _____
- ✓ **Has patient undergone surgery for brain lesion(s):** ☐ Yes ☐ No ☐ Unknown
- ✓ **Prior radiation to the head:** ☐ Yes ☐ No ☐ Unknown
- ✓ **Whole brain or partial brain treatment planned:** ☐ Whole Brain ☐ Partial Brain (No WBRT) ☐ Unknown
- ✓ **What is the patient's performance status? (ECOG Scale)**
  - ☐ 0 – Fully active, able to carry on all pre-disease performance without restriction
  - ☐ 1 – Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature
  - ☐ 2 – Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
  - ☐ 3 – Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
  - ☐ 4 – Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair

☐ Spine Metastasis

^ Tumor amenable to surgery: ☐ Yes ☐ No ☐ Unknown **^ Tumor causing intractable pain:** ☐ Yes ☐ No ☐ Unknown
^ Tumor causing spinal cord compression: ☐ Yes ☐ No ☐ Unknown

☐ Other Metastasis

- ✓ **Why is the patient receiving radiation treatment:** _____
- ✓ **Treatment intent/timing:** ☐ Primary ☐ Adjuvant radiation therapy ☐ Unknown
- ✓ **Initial or recurrent tumor:** ☐ Initial Tumor ☐ Recurrent Tumor ☐ Unknown

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 _____

Central Nervous System (CNS) Metastatic Cancer
Radiation Therapy Treatment Plan Checklist

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
☐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