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>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Oncologist :</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy Facility :</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Planning Start Date (i.e. Initial Simulation)</td>
<td>Anticipated Treatment Start Date</td>
<td></td>
</tr>
</tbody>
</table>

### Patient Clinical Information

- **Type of tumor being treated:** ______________________________________________________
- **Treatment intent/timing:**
  - Primary
  - Adjuvant radiation therapy
  - Unknown
  - Other ________________________________
- **Recurrent tumor:**
  - Yes
  - No
  - 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**
  - Fractions: _____
- **3D Conformal**
  - Number of ports/arcs/fields: _____
- **IMRT**
  - Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined?  
    - Yes
    - No

#### IMRT Only

  - Which technique will be used?
    - Linac Multi-Angle
    - Compensator-Based
    - Helical
    - Arc Therapy
    - Other

  - Will the IMRT course of therapy be inversely planned?  
    - Yes
    - No

#### Stereotactic Body RT (SBRT)

  - Fractions: _____
  - Number of ports/arcs/fields: _____

  - 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

#### IGRT Technique

  - None (select none for port films)
  - CT Guidance (Conebeam CT)
  - Stereoscopic Guidance (kV or mV with fiducial markers)

- At what frequency will the IGRT be performed?  
  - Daily
  - 1 time per week
  - Other __________________

**IMRT Note:** IMRT treatment requests will 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.
**Primary Bone Cancer Radiation Therapy Treatment Plan Checklist**

### Boost Phase 1 – Select Therapy

<p>| | |</p>
<table>
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<td><strong>IMRT</strong></td>
<td>✓ Will a new CT be performed? ☐ Yes ☐ No ☐ NA</td>
</tr>
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### Boost Phase 2 – Select Therapy

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</tr>
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</tr>
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**IMRT Note:** IMRT treatment requests will 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.

### Special Services – Please note if you are faxing additional information

- ☐ **Special Dosimetry (CPT® 77331)** Provide requested quantity and the rationale for performing the service.
- ☐ **Special Physics Consultation (CPT® 77370)** Provide the rationale for performing the service.
- ☐ **Special Treatment Procedure (CPT® 77470)** Provide the rationale for performing the service.