Cervical 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](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

- **✓ Treatment Timing:**
  - [ ] Definitive (Primary)
  - [ ] Pre-Operative
  - [ ] Post-Operative
- **✓ FIGO Stage:**
  - [ ] Stage IA1
  - [ ] Stage IA2
  - [ ] Stage IB1
  - [ ] Stage IB2
  - [ ] Stage IIA
  - [ ] Stage IIB
  - [ ] Stage IIIA
  - [ ] Stage IVA
- **✓ Tumor size in centimeters (cm):** [__________]
- **✓ Deep cervical stromal invasion:**
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
  - [ ] Distant metastasis:
    - [ ] Yes
    - [ ] No
    - [ ] Unknown
- **✓ Lymphovascular space invasion:**
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
  - [ ] N/A
  - [ ] Palliative treatment:
    - [ ] Yes
    - [ ] No
    - [ ] Unknown
- **✓ Positive pelvic nodes:**
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
- **✓ Positive paraaortic nodes:**
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
- **✓ Parametrial invasion:**
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
- **✓ Distant metastasis:**
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
- **✓ Palliative treatment:**
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
  - [ ] Reason for palliative treatment: [____________]
- **✓ Previous radiation for cervical cancer:**
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
- **✓ Concurrent chemotherapy:**
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
- **✓ Reason for concurrent chemotherapy:** [__________]

### 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: [______]
  - [ ] Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined? [ ] Yes [ ] No

#### IMRT

- **[ ] IMRT**
  - [ ] 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

**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.

- **[ ] High Dose Rate (HDR) Brachytherapy**
  - [ ] Fractions: [______]
  - [ ] Will a tumor volume and at least one critical structure be contoured? [ ] Yes [ ] No
  - [ ] HDR Image Guidance Technique: [ ] None [ ] CT Guidance [ ] X-ray films [ ] Ultrasound

- **[ ] Low Dose Rate (LDR) Brachytherapy**
  - [ ] Fractions: [______]
  - [ ] Will a tumor volume and at least one critical structure be contoured? [ ] Yes [ ] No

- **[ ] 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 [______________]

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**Boost Phase 1 – Select Therapy**

- **2-Dimension**
  - **Fractions:** ______

- **3D Conformal**
  - **Number of ports/arcs/fields:** ______

- **IMRT**
  - **Will a new CT be performed?**  
    - [ ] Yes  
    - [ ] No  
    - [ ] NA

  **IMRT Only**
  - **Which technique will be used?**
    - [ ] Linac Multi-Angle  
    - [ ] Compensator-Based  
    - [ ] Helical  
    - [ ] Arc Therapy  
    - [ ] Other

- **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 ________________

- **High Dose Rate (HDR)**
  - **Fractions:** ______

- **Low Dose Rate (LDR)**
  - **Image Guidance Technique:**
    - [ ] None  
    - [ ] CT Guidance  
    - [ ] Ultrasound  
    - [ ] X-ray films

  - **Will a tumor volume and at least one critical structure be contoured for planning?**  
    - [ ] Yes  
    - [ ] No

**Boost Phase 2 – Select Therapy**

- **2-Dimension**
  - **Fractions:** ______

- **3D Conformal**
  - **Number of ports/arcs/fields:** ______

- **IMRT**
  - **Will a new CT be performed?**  
    - [ ] Yes  
    - [ ] No  
    - [ ] NA

  **IMRT Only**
  - **Which technique will be used?**
    - [ ] Linac Multi-Angle  
    - [ ] Compensator-Based  
    - [ ] Helical  
    - [ ] Arc Therapy  
    - [ ] Other

- **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 ________________

- **High Dose Rate (HDR)**
  - **Fractions:** ______

- **Low Dose Rate (LDR)**
  - **Image Guidance Technique:**
    - [ ] None  
    - [ ] CT Guidance  
    - [ ] Ultrasound  
    - [ ] X-ray films

**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.