# Endometrial 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

- ✓ **Uterus primary site being treated:** ☐Yes ☐No ☐Unknown
- ✓ **FIGO Stage:** ☐ Stage I ☐ Stage IA ☐ Stage IB ☐ Stage II ☐ Stage IIIA ☐ Stage IIIB ☐ Stage IIIC ☐ Stage IV
- ✓ **Distant metastasis:** ☐Yes ☐No ☐Unknown
- ✓ **Tumor Grade:** ☐Grade I ☐Grade II ☐Grade III
- ✓ **Treatment Intent :** ☐ Pre-Operative ☐ Post-Operative ☐ Medically Inoperable/Primary
- ✓ **Reason for palliative treatment:** _____
- ✓ **Any of the following risk factors present:** ☐ Lymphovascular space invasion ☐Lower uterine involvement ☐Patient 60 years old or older

## 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**

- ✓ Fractions: _____
- ✓ 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 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)**
☐ **Low Dose Rate (LDR)** ✓ Fractions: _____

✓ Image Guidance Technique: ☐None ☐CT Guidance ☐Ultrasound ☐X-ray films

## 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)**
☐ **Low Dose Rate (LDR)** ✓ Fractions: _____

✓ 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.