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

<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

- 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

<table>
<thead>
<tr>
<th>2-Dimension</th>
<th>3D Conformal</th>
<th>IMRT</th>
<th>IMRT Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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
- 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  _____________________
### Endometrial Cancer Radiation Therapy Treatment Plan Checklist

#### 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

#### 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.