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>
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<tr>
<th>Radiation Oncologist</th>
<th>Radiation Therapy Facility</th>
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<tr>
<th>Treatment Planning Start Date (i.e. Initial Simulation)</th>
<th>Anticipated Treatment Start Date</th>
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### Patient Clinical Information

- **Primary tumor site being treated:**
  - Cancer of Oral Cavity
  - Oropharynx
  - Hypopharynx
  - Nasopharynx
  - Glottic Larynx
  - Supraglottic Larynx
  - Paranasal Sinus
  - Other

- **T Stage:**
  - TX
  - T0
  - T1
  - T2
  - T3
  - T4
  - Does patient have distant metastasis (M1)?
    - Yes
    - No

- **N Stage:**
  - NX
  - N0
  - N1
  - N2
  - N3

- **Positive margins:**
  - Yes
  - No
  - Unknown

- **Treatment intent:**
  - Curative
  - Palliative
  - Unknown

- **Reason for palliative treatment:**

- **Treatment timing:**
  - Pre-operative
  - Post-operative
  - Definitive
  - Recurrence

- **Adverse risk factors:**
  - Positive node
  - pT3 or pT4
  - Perineural invasion
  - Vascular tumor embolism
  - Other

- **List all post-operative risk factors:**

### 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

- **Proton**
  - 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

- **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
**Head and Neck 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.

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