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

- Location of the tumor being treated: ________________________________
- Treatment Intent: ☐ Curative ☐ Palliative ☐ Unknown
- Stage: ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV
- Type of lymphoma: ☐ Follicular ☐ Mantle Cell ☐ MALT ☐ Diffuse Large B Cell ☐ Burkitt’s ☐ Other
- Bulky disease: ☐ Yes ☐ No ☐ Unknown
- Receive chemotherapy or chemotherapy planned: ☐ 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
- ☐ 3D Conformal
- ☐ 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.

- ☐ 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 ________________
Non-Hodgkin’s Lymphoma Radiation Therapy Treatment Plan Checklist

**Boost Phase 1 – Select Therapy**

<table>
<thead>
<tr>
<th></th>
<th>2-Dimension</th>
<th>3D Conformal</th>
<th>IMRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractions</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Number of ports/arcs/fields</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Will a new CT be performed?</td>
<td>Yes □</td>
<td>No □</td>
<td>NA □</td>
</tr>
</tbody>
</table>

**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 □

**Boost Phase 2 – Select Therapy**

<table>
<thead>
<tr>
<th></th>
<th>2-Dimension</th>
<th>3D Conformal</th>
<th>IMRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractions</td>
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<td>✓</td>
<td></td>
</tr>
<tr>
<td>Number of ports/arcs/fields</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Will a new CT be performed?</td>
<td>Yes □</td>
<td>No □</td>
<td>NA □</td>
</tr>
</tbody>
</table>

**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 □

**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.