**Other Cancer or Condition - 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>Breast Surgeon:</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></td>
<td>Anticipated Treatment Start Date:</td>
</tr>
</tbody>
</table>

### Patient Clinical Information

- **T – Stage:**
  - [ ] TX
  - [ ] T0
  - [ ] Tis
  - [ ] T1
  - [ ] T2
  - [ ] T3
  - [ ] T4
- **Distant Mets:**
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
- **“Other” condition being treated:** __________________________________________________________________________
- **Original tumor resected?:**
  - [ ] Yes
  - [ ] No, tumor unresectable
  - [ ] No, tumor may be resected in future
- **Treatment intent/timing:**
  - [ ] Primary
  - [ ] Adjuvant radiation therapy
  - [ ] Unknown
- **Initial or recurrent tumor:**
  - [ ] Initial
  - [ ] Recurrent
  - [ ] Unknown
- **Previous radiation to this site?:**
  - [ ] 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

<table>
<thead>
<tr>
<th>2-Dimension</th>
<th>Fractions: _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>3D Conformal</td>
<td>Number of ports/arcs/fields: _____</td>
</tr>
<tr>
<td>IMRT</td>
<td></td>
</tr>
<tr>
<td>Proton</td>
<td></td>
</tr>
</tbody>
</table>

- **IMRT Only**
  - 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

#### Stereotactic Body RT (SBRT)

- **Which technique will be used?**
  - [ ] Robotic - Linac Multi-Angle
  - [ ] Non-Robotic – Linac Multi-Angle

- **Fractions: _____**
- **Number of ports/arcs/fields: _____**

#### IGRT Technique

- **At what frequency will the IGRT be performed?**
  - [ ] Daily
  - [ ] 1 time per week
  - [ ] Other _____________________

#### 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

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### Boost Phase 1 – Select Therapy

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<tr>
<th>Option</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>2-Dimension</td>
<td>✓ Fractions: _____</td>
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<tr>
<td>IMRT</td>
<td>✓ Will a new CT be performed?</td>
</tr>
<tr>
<td>IMRT Only</td>
<td>✓ Which technique will be used?</td>
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<td>Linac Multi-Angle, Compensator-Based, Helical, Arc Therapy, Other</td>
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### Boost Phase 2 – Select Therapy

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<th>Details</th>
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<tbody>
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<tr>
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<tr>
<td>IMRT</td>
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<tr>
<td>IMRT Only</td>
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<td>Linac Multi-Angle, Compensator-Based, Helical, Arc Therapy, Other</td>
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### 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 ________________

### Special Services – Please note if you are faxing additional information

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Dosimetry</td>
<td>(CPT® 77331) Provide requested quantity and the rationale for performing the service</td>
</tr>
<tr>
<td>Special Physics Consultation</td>
<td>(CPT® 77370) Provide the rationale for performing the service.</td>
</tr>
<tr>
<td>Special Treatment Procedure</td>
<td>(CPT® 77470) Provide the rationale for performing the service.</td>
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