Other Metastatic 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

- **Location of metastatic disease?**
  - [ ] Adrenal Gland
  - [ ] Liver
  - [ ] Lung
  - [ ] Lymph Nodes
    - Node location ____________
  - [ ] Peritoneum
  - [ ] Skin/Muscle
  - [ ] Spine
  - [ ] Vagina
  - [ ] Other _____________________

- **Primary cancer site of the metastatic disease being treated?**
  - [ ] Anal
  - [ ] Bone
  - [ ] Breast
  - [ ] Central Nervous System
  - [ ] Cervix
  - [ ] Colorectal
  - [ ] Endometrial
  - [ ] Gastric
  - [ ] Head & Neck
  - [ ] Hodgkins Lymphoma
  - [ ] Non-Hodgkins Lymphoma
  - [ ] Pancreas
  - [ ] Prostate
  - [ ] Non-Small Cell Lung Cancer
  - [ ] Small Cell Lung Cancer
  - [ ] Unknown
  - [ ] Other ______________________________________________

### 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
- [ ] Proton
  - 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
    - [ ] Robotic - Tomotherapy
    - [ ] Non-Robotic - Tomotherapy
    - [ ] Robotic - Cyberknife
    - [ ] Non-Robotic – Gamma Knife
  - [ ] Fractions: ________
  - [ ] Number of ports/arcs/fields: ________

- [ ] IGRT Technique
  - [ ] None (select none for port films)
  - [ ] CT Guidance (Conebeam CT)
  - [ ] Stereoscopic Guidance (kV or mV with fiducial markers)
  - [ ] Other ________________
  - [ ] At what frequency will the IGRT be performed? [Daily] [1 time per week] [Other] ________________
### Initial Treatment Phase – Continued

<table>
<thead>
<tr>
<th><strong>High Dose Rate (HDR) Brachytherapy</strong></th>
<th>✔ Fractions: _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Will a tumor volume and at least one critical structure be contoured?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>✔ HDR Image Guidance Technique: □ None □ CT Guidance □ X-ray films □ Ultrasound</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Low Dose Rate (LDR) Brachytherapy</strong></th>
<th>✔ Fractions: _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Will a tumor volume and at least one critical structure be contoured?</td>
<td>□ Yes □ No</td>
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</table>

### Boost Phase 1 – Select Therapy

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<td><strong>3D Conformal</strong></td>
<td>✔ Number of ports/arcs/fields: _____</td>
</tr>
<tr>
<td><strong>IMRT</strong></td>
<td>✔ Will a new CT be performed? □ Yes □ No □ NA</td>
</tr>
</tbody>
</table>

**IMRT Only** ✔ Which technique will be used? □ Linac Multi-Angle □ Compensator-Based □ Helical □ Arc Therapy □ Other

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<tr>
<th><strong>IGRT Technique</strong></th>
<th>□ None (select none for port films) □ CT Guidance (Conebeam CT) □ Stereoscopic Guidance (kV or mV with fiducial markers) □ Other</th>
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✔ At what frequency will the IGRT be performed? □ Daily □ 1 time per week □ Other _____________________

### Boost Phase 2 – Select Therapy

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<th><strong>2-Dimension</strong></th>
<th>✔ Fractions: _____</th>
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<td>✔ Number of ports/arcs/fields: _____</td>
</tr>
<tr>
<td><strong>IMRT</strong></td>
<td>✔ Will a new CT be performed? □ Yes □ No □ NA</td>
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**IMRT Only** ✔ Which technique will be used? □ Linac Multi-Angle □ Compensator-Based □ Helical □ Arc Therapy □ Other

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<tr>
<th><strong>IGRT Technique</strong></th>
<th>□ None (select none for port films) □ CT Guidance (Conebeam CT) □ Stereoscopic Guidance (kV or mV with fiducial markers) □ Other</th>
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✔ At what frequency will the IGRT be performed? □ Daily □ 1 time per week □ Other _____________________

### 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.