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

Patient Name :	DOB:	Health Plan ID :
Radiation Oncologist :		
Radiation Therapy Facility :		
Treatment Planning Start Date (i.e. Initial Simulation):	Anticipated Treatment Start Date:	

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**

✓ 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

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

☐ **Stereotactic Body RT (SBRT)** ✓ Fractions: _____ ✓ Number of ports/arcs/fields: _____

✓ Which technique will be used?
☐ Robotic -Linac Multi-Angle ☐ Robotic- Tomotherapy ☐ Robotic -Cyberknife
☐ Non-Robotic – Linac Multi-Agle ☐ Non–Robotic - Tomotherapy ☐ Non–Robotic – Gamma Knife

☐ **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 _____

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Initial Treatment Phase – Continued

☐ **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

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) ☐Other _____

✓ At what frequency will the IGRT be performed? ☐Daily ☐1 time per week ☐Other _____

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) ☐Other _____

✓ 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.