Pancreas 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

✓ **Treatment timing:** ☐ Definitive/Unresectable ☐ Pre-operative ☐ Borderline Resectable ☐ Post-operative ☐ Local recurrence

✓ **Distant metastasis:** ☐ Yes ☐ No ☐ Unknown

✓ **Treatment intent:** ☐ Curative ☐ Palliative ☐ Unknown

✓ **Receiving concurrent chemotherapy:** ☐ Yes ☐ No ☐ Unknown

✓ **Previous radiation to pancreas:** ☐ Yes ☐ No ☐ Unknown

✓ **Reason for palliative treatment:** _____

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)

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

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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 _____		

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 _____		

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.