

# Non- Small Cell Lung 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](http://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		
<input checked="" type="checkbox"/> <b>Treatment Intent :</b>	<input type="checkbox"/> Pre- Operative <input type="checkbox"/> Primary Therapy- Inoperable	<input type="checkbox"/> Post-Operative – Adjuvant <input type="checkbox"/> Palliative
<b>T Stage:</b> <input type="checkbox"/> TX <input type="checkbox"/> T0 <input type="checkbox"/> Tis <input type="checkbox"/> T1 <input type="checkbox"/> T2 <input type="checkbox"/> T3 <input type="checkbox"/> T4	<b>N Stage:</b> <input type="checkbox"/> NX <input type="checkbox"/> N0 <input type="checkbox"/> N2 <input type="checkbox"/> N1 <input type="checkbox"/> N3  <b>Does patient have distant metastasis (M1)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> If palliative, what is the reason for radiation therapy? (e.g. airway obstruction, hemoptysis pain, etc.)  <input checked="" type="checkbox"/> Margin Status (Post Operative Only): <input type="checkbox"/> Negative <input type="checkbox"/> Close <input type="checkbox"/> Positive <input type="checkbox"/> N/A <input checked="" type="checkbox"/> Is there extracapsular nodal extension? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Is chemotherapy planned? <input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Planning Information		
<input checked="" type="checkbox"/> <b>What is the prescription radiation dose for the ENTIRE course of external beam treatment?</b>		<b>Gy</b>
Initial Treatment Phase - Select Therapy		
<input type="checkbox"/> <b>2-Dimension</b>	<input checked="" type="checkbox"/> Fractions : _____	
<input type="checkbox"/> <b>3D Conformal</b>	<input checked="" type="checkbox"/> Number of ports/arcs/fields: _____	
<input type="checkbox"/> <b>IMRT</b>	<input checked="" type="checkbox"/> Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>IMRT Only</b>	<input checked="" type="checkbox"/> Which technique will be used? <input type="checkbox"/> Linac Multi-Angle <input type="checkbox"/> Compensator-Based <input type="checkbox"/> Helical <input type="checkbox"/> Arc Therapy <input type="checkbox"/> Other	
	<input checked="" type="checkbox"/> Will techniques to account for respiratory motion be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i><b>Note:</b> 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 and tissue constraints and target goals of the plan. Field in field or forward planning is not considered IMRT.</i>		
<input type="checkbox"/> <b>SBRT</b>	<input checked="" type="checkbox"/> Number of ports/arcs/fields: _____	<input checked="" type="checkbox"/> Fractions : _____
<input checked="" type="checkbox"/> Which technique will be used? <input type="checkbox"/> Robotic -Linac Multi-Angle <input type="checkbox"/> Robotic- Tomotherapy <input type="checkbox"/> Robotic -Cyberknife <input type="checkbox"/> Non -Robotic		
<input type="checkbox"/> <b>High Dose Rate (HDR) Brachytherapy:</b>	<input checked="" type="checkbox"/> Fractions: _____	
<input checked="" type="checkbox"/> Will a tumor volume and at least one critical structure be contoured for brachytherapy planning? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> <b>Image Guidance (IGRT)</b>	<input type="checkbox"/> None (select none for port films)	<input type="checkbox"/> CT Guidance (Conebeam CT) <input type="checkbox"/> Stereoscopic Guidance (kV or mV) <input type="checkbox"/> Other _____
<b>Technique:</b>		
<input checked="" type="checkbox"/> At what frequency will the IGRT be performed? <input type="checkbox"/> Daily <input type="checkbox"/> 1 time per week <input type="checkbox"/> Other _____		

## Non- Small Cell Lung Cancer Radiation Therapy Treatment Plan Checklist

Boost Phase 1 – Select Therapy	
<input type="checkbox"/> <b>2-Dimension</b>	✓ Fractions : _____
<input type="checkbox"/> <b>3D Conformal</b>	✓ Number of ports/arcs/fields: _____
<input type="checkbox"/> <b>IMRT</b>	✓ Will a new CT be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>IMRT Only</b>	✓ Which technique will be used? <input type="checkbox"/> Linac Multi-Angle <input type="checkbox"/> Compensator-Based <input type="checkbox"/> Helical <input type="checkbox"/> Arc Therapy <input type="checkbox"/> Other
	✓ Will techniques to account for respiratory motion be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Image Guidance (IGRT) Technique:</b>	<input type="checkbox"/> None (select none for port films) <input type="checkbox"/> CT Guidance (Conebeam CT) <input type="checkbox"/> Stereoscopic Guidance (kV or mV) <input type="checkbox"/> Other _____
	✓ At what frequency will the IGRT be performed? <input type="checkbox"/> Daily <input type="checkbox"/> 1 time per week <input type="checkbox"/> Other _____
Boost Phase 2 – Select Therapy	
<input type="checkbox"/> <b>2-Dimension</b>	✓ Fractions : _____
<input type="checkbox"/> <b>3D Conformal</b>	✓ Number of ports/arcs/fields: _____
<input type="checkbox"/> <b>IMRT</b>	✓ Will a new CT be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>IMRT Only</b>	✓ Which technique will be used? <input type="checkbox"/> Linac Multi-Angle <input type="checkbox"/> Compensator-Based <input type="checkbox"/> Helical <input type="checkbox"/> Arc Therapy <input type="checkbox"/> Other
	✓ Will techniques to account for respiratory motion be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Image Guidance (IGRT) Technique:</b>	<input type="checkbox"/> None (select none for port films) <input type="checkbox"/> CT Guidance (Conebeam CT) <input type="checkbox"/> Stereoscopic Guidance (kV or mV) <input type="checkbox"/> Other _____
	✓ At what frequency will the IGRT be performed? <input type="checkbox"/> Daily <input type="checkbox"/> 1 time per week <input type="checkbox"/> Other _____
<b>Note:</b> 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 and tissue constraints and target goals of the plan. Field in field or forward planning is not considered IMRT.	
Special Services – Please note if you are faxing additional information	
<input type="checkbox"/> <b>Special Dosimetry (CPT® 77331)</b> Provide requested quantity and the rationale for performing the service.	
<input type="checkbox"/> <b>Special Physics Consultation (CPT® 77370)</b> Provide the rationale for performing the service.	
<input type="checkbox"/> <b>Special Treatment Procedure (CPT® 77470)</b> Provide the rationale for performing the service.	