Bone 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. Additional clinical information may be requested (i.e., radiation therapy consultation, comparison plan, clinical treatment plan notes, pathology report, recent imaging report, treatment prescription, prior treatment summary, etc.).

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

✓ **Site of primary cancer:** ☐ Breast ☐ Prostate ☐ Lung ☐ Other _____ ☐ Unknown

✓ **How many sites are being treated:** ☐ Single Site ☐ Two or More Sites ☐ Unknown

✓ **Location of the bone mets being treated:** ☐ Spine ☐ Femur ☐ Pelvis ☐ Rib ☐ Humerus ☐ Shoulder ☐ Skull ☐ Other _____

✓ **Reason for treatment (e.g., pain, spinal cord compression, etc.):** _____

✓ **List other sites with metastatic disease:** _____

✓ **What is the patient's performance status? (ECOG Scale)**

- ☐ 0 – Fully active, able to carry on all pre-disease performance without restriction
- ☐ 1 – Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work
- ☐ 2 – Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
- ☐ 3 – Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
- ☐ 4 – Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair

✓ **Has patient had prior radiation for bone metastasis:** ☐ 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

☐ **2-Dimension** ☐ **3D Conformal** ☐ **IMRT** ☐ **SRS/SBRT** ☐ **Proton**

☐ **HDR Brachytherapy** ☐ **LDR Brachytherapy** ☐ **Other _____**

Fractions: _____

IMRT ONLY:

✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Compensator-Based ☐ Helical ☐ Arc Therapy ☐ Other

Note: IMRT treatment requests may require review for medical necessity by a radiation oncologist. Clinical rationale for performing IMRT is required and should include a 3D-CRT vs IMRT comparison plan, tissue constraints including all values/doses for all organs at risk and target goals of the plan.

SRS/SBRT ONLY:

✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Tomotherapy ☐ CyberKnife ☐ Gamma Knife ☐ Other

IGRT: ☐ None (Select for Port Films)
☐ Yes

✓ At what frequency will IGRT be performed: ☐ Daily ☐ 1 time per week ☐ other _____

Boost Phase 1 – Select Therapy

☐ **2-Dimension** ☐ **3D Conformal** ☐ **IMRT** ☐ **SRS/SBRT** ☐ **Proton**
☐ **HDR Brachytherapy** ☐ **LDR Brachytherapy** ☐ **Other**

Fractions: _____

IMRT ONLY:
✓ Which technique will be used? ☐Linac Multi-Angle ☐Compensator-Based ☐Helical ☐Arc Therapy ☐Other

SBRT ONLY:
Which technique will be used? ☐ Linac Multi-Angle ☐ Tomotherapy ☐ CyberKnife ☐ Gamma Knife ☐ Other

IGRT: ☐ None (Select for Port Films)
☐ Yes
✓ At what frequency will IGRT be performed: ☐ Daily ☐ 1 time per week ☐ other _____

Boost Phase 2 – Select Therapy

☐ **2-Dimension** ☐ **3D Conformal** ☐ **IMRT** ☐ **SRS/SBRT** ☐ **Proton**
☐ **HDR Brachytherapy** ☐ **LDR Brachytherapy** ☐ **Other** _____

Fractions: _____

IMRT ONLY:
✓ Which technique will be used? ☐Linac Multi-Angle ☐Compensator-Based ☐Helical ☐Arc Therapy ☐Other

SBRT ONLY:
✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Tomotherapy ☐ CyberKnife ☐ Gamma Knife ☐ Other

IGRT: ☐ None (Select for Port Films)
☐ Yes
✓ At what frequency will IGRT be performed: ☐ Daily ☐ 1 time per week ☐ other _____