# Breast 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 Magellan 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: | Breast Surgeon: | |
| Radiation Therapy Facility: | | |
| Treatment Planning Start Date (i.e., Initial Simulation): | Anticipated Treatment Start Date: | |

## Patient Clinical Information

✓ **Treatment Intent:** ☐ Curative ☐ Palliative

✓ **Treatment Timing:** ☐ Post-Lumpectomy ☐ Post-Mastectomy ☐ Other

**T Stage:**
☐ TX
☐ Tis (DCIS)
☐ Tis (LCIS)
☐ T1
☐ T2
☐ T3
☐ T4

**N Stage:**
☐ NX
☐ N0 ☐ N2
☐ N1 ☐ N3

**Does patient have distant metastasis (M1)?**
☐ Yes ☐ No

✓ **Breast Being Treating:** ☐ Right Breast ☐ Left Breast.

✓ **Area Being Treated:** ☐ Whole Breast ☐ Partial Breast ☐ Chest Wall.

✓ **Is this a recurrent tumor?** ☐ Yes ☐ No

✓ **Lymph Node Involvement:** ☐ None ☐ Regional ☐ Sentinel ☐ Both Regional/Sentinel

✓ **Margin Status:** ☐ Negative ☐ Close ☐ Positive

✓ **Is nodal radiation planned?** ☐ Yes ☐ No

✓ **Has patient received pre-operative chemotherapy:** ☐ Yes ☐ No

**For APBI Only**

✓ **Tumor Size (cm):**

✓ **Clinically Unifocal Tumor:** ☐ Yes ☐ No

✓ **BRCA 1 or 2 Mutation:** ☐ Yes ☐ No ☐ NA

## 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**

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

**Fractions:** _____

**IMRT ONLY:**

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

**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 2 – Select Therapy

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

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

**Fractions:** _____

**IMRT ONLY:**

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

**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