Cervical 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

✓ **Treatment Timing:** ☐ Definitive (Primary) ☐ Pre-Operative ☐ Post-Operative

✓ **FIGO Stage:** ☐ Stage IA1 ☐ Stage IA2 ☐ Stage IB1 ☐ Stage IB2 ☐ Stage IIA ☐ Stage IIB ☐ Stage IIIA ☐ Stage IVA

✓ **Tumor size in centimeters (cm):** _____

✓ **Deep cervical stromal invasion:** ☐Yes ☐No ☐Unknown

✓ **Lymphovascular space invasion:** ☐Yes ☐No ☐Unknown ☐N/A

✓ **Positive pelvic nodes:** ☐Yes ☐No ☐ Unknown

✓ **Positive paraaortic nodes:** ☐Yes ☐No ☐ Unknown

✓ **Parametrial invasion:** ☐Yes ☐No ☐ Unknown

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

✓ **Palliative treatment:** ☐Yes ☐No ☐Unknown

✓ **Reason for palliative treatment:** _____

✓ **Previous radiation for cervical cancer:** ☐Yes ☐No ☐Unknown

✓ **Concurrent chemotherapy:** ☐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 be reviewed 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

Initial Treatment Phase –(Continued)

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

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

LDR ONLY:
If any portion of the patient's radiation oncology treatment will be performed in a facility or hospital other than the facility previously stated,

what is the name of that facility? _____

Which portion of the treatment will be performed at the additional facility? ☐**NA** ☐**Initial Phase** ☐**Boost Phase**

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**

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