Central Nervous System (CNS) 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

☐ Brain Metastasis

✓ **Site of primary cancer:** ☐ Bladder ☐ Breast ☐ Colorectal ☐ Head/Neck ☐ Lung ☐ Prostate ☐ Other _____

✓ **Active cancer in another organ system:** ☐ Yes ☐ No ☐ Unknown

✓ **Receiving radiation treatment to another site:** ☐ Yes ☐ No ☐ Unknown

✓ **If systemic disease, is it controlled:** ☐ Yes ☐ No ☐ Unknown

✓ **How many lesions are present:** _____ **Size of lesions in cm:** _____

✓ **Has patient undergone surgery for brain lesion(s):** ☐ Yes ☐ No ☐ Unknown

✓ **Prior radiation to the head:** ☐ Yes ☐ No ☐ Unknown

✓ **Whole brain or partial brain treatment planned:** ☐ Whole Brain ☐ Partial Brain (No WBRT) ☐ Unknown

✓ **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**
- ☐ **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**

☐ Spine Metastasis

✓ **Tumor amenable to surgery:** ☐ Yes ☐ No ☐ Unknown

✓ **Tumor causing intractable pain:** ☐ Yes ☐ No ☐ Unknown

✓ **Tumor causing spinal cord compression:** ☐ Yes ☐ No ☐ Unknown

☐ Other Metastasis

✓ **Why is the patient receiving radiation treatment?** _____

✓ **Treatment intent/timing:** ☐ Primary ☐ Adjuvant radiation therapy ☐ Unknown

✓ **Initial or recurrent tumor:** ☐ Initial Tumor ☐ Recurrent Tumor ☐ 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.

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Initial Treatment Phase (continued)

SRS/SBRT ONLY:

✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Tomotherapy ☐ CyberKnife ☐ Gamm 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

SRS/SBRT ONLY:

✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Tomotherapy ☐ CyberKnife ☐ Gamm 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

SRS/SBRT ONLY:

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

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

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