



# 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. 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		
<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"/> N1 <input type="checkbox"/> N2 <input type="checkbox"/> N3 <b>Does patient have distant metastasis (M1)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Cancer Stage: <input type="checkbox"/> Limited <input type="checkbox"/> Extensive <input checked="" type="checkbox"/> Treatment Intent: <input type="checkbox"/> Curative <input type="checkbox"/> Palliative <input checked="" type="checkbox"/> If palliative, what is the reason for radiation therapy? (e.g., airway obstruction, hemoptysis pain, etc.) <input checked="" type="checkbox"/> Is chemotherapy planned: <input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Planning Information		
<input checked="" type="checkbox"/> What is the prescription radiation dose for the <u>ENTIRE</u> course of external beam treatment?		Gy
Initial Treatment Phase - Select Therapy		
<input type="checkbox"/> 2-Dimension <input type="checkbox"/> 3D Conformal <input type="checkbox"/> IMRT <input type="checkbox"/> SRS/SBRT <input type="checkbox"/> Proton <input type="checkbox"/> HDR Brachytherapy <input type="checkbox"/> LDR Brachytherapy <input type="checkbox"/> Other _____		
Fractions: _____		
<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 <u>Note:</u> 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.		
<b>SRS/SBRT ONLY:</b> <input checked="" type="checkbox"/> Which technique will be used? <input type="checkbox"/> Linac Multi-Angle <input type="checkbox"/> Tomotherapy <input type="checkbox"/> CyberKnife <input type="checkbox"/> Gamma Knife <input type="checkbox"/> Other		
<b>IGRT:</b> <input type="checkbox"/> None (Select for Port Films) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> At what frequency will IGRT be performed: <input type="checkbox"/> Daily <input type="checkbox"/> 1 time per week <input type="checkbox"/> other		



Boost Phase 1 – Select Therapy	
<input type="checkbox"/> 2-Dimension	<input type="checkbox"/> 3D Conformal
<input type="checkbox"/> HDR Brachytherapy	<input type="checkbox"/> LDR Brachytherapy
<input type="checkbox"/> IMRT	<input type="checkbox"/> SRS/SBRT
<input type="checkbox"/> Proton	<input type="checkbox"/> Other _____
Fractions: _____	
<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	
<b>SRS/SBRT ONLY:</b>	
✓ Which technique will be used?	<input type="checkbox"/> Robotic Linac Multi-Angle
<input type="checkbox"/> Non-Robotic - Linac Multi-Angle	<input type="checkbox"/> Robotic - Tomotherapy
<input type="checkbox"/> Unknown	<input type="checkbox"/> Non-Robotic - _____
	<input type="checkbox"/> Robotic - CyberKnife
	<input type="checkbox"/> Non-Robotic - Gamma Knife
	<input type="checkbox"/> Other _____
<b>IGRT:</b> <input type="checkbox"/> None (Select for Port Films)	
<input type="checkbox"/> Yes	
✓ At what frequency will 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"/> 2-Dimension	<input type="checkbox"/> 3D Conformal
<input type="checkbox"/> HDR Brachytherapy	<input type="checkbox"/> LDR Brachytherapy
<input type="checkbox"/> IMRT	<input type="checkbox"/> SRS/SBRT
<input type="checkbox"/> Proton	<input type="checkbox"/> Other _____
Fractions: _____	
<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	
<b>SRS/SBRT ONLY:</b>	
✓ Which technique will be used?	<input type="checkbox"/> Linac Multi-Angle
<input type="checkbox"/> Tomotherapy	<input type="checkbox"/> CyberKnife
<input type="checkbox"/> Other _____	<input type="checkbox"/> Gamma Knife
	<input type="checkbox"/> Other _____
<b>IGRT:</b> <input type="checkbox"/> None (Select for Port Films)	
<input type="checkbox"/> Yes	
✓ At what frequency will IGRT be performed: <input type="checkbox"/> Daily <input type="checkbox"/> 1 time per week <input type="checkbox"/> other	