



# Skin 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		
<input checked="" type="checkbox"/> <b>Type of Skin Cancer:</b> <input type="checkbox"/> Basal Cell <input type="checkbox"/> Squamous Cell <input type="checkbox"/> Melanoma <input type="checkbox"/> Other Specify: _____		
<input checked="" type="checkbox"/> <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 <input type="checkbox"/> Unknown		
<input checked="" type="checkbox"/> <b>How many sites are being treated:</b> <input type="checkbox"/> One <input type="checkbox"/> Two or More		
<b>*When treating two or more sites, separate authorizations are required for each site being treated.*</b>		
<input checked="" type="checkbox"/> <b>Location of the skin lesion being treated:</b> _____		
<b>Treatment intent/timing:</b> <input type="checkbox"/> Definitive <input type="checkbox"/> Post resection (primary site or node) <input type="checkbox"/> Recurrent disease <input type="checkbox"/> Palliative		
<input checked="" type="checkbox"/> <b>Previous radiation to this site?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Treatment Planning Information		
<input checked="" type="checkbox"/> <b>What is the prescription radiation dose for the <u>ENTIRE</u> course of treatment?</b>	<b>Gy</b>	
Initial Treatment Phase – Select Therapy		
<input type="checkbox"/> <b>2-Dimension</b>	<input checked="" type="checkbox"/> Fractions: _____	
<input type="checkbox"/> <b>3D Conformal</b>	<input checked="" type="checkbox"/> Number of ports/arcs/fields: _____	
<input type="checkbox"/> <b>IMRT</b>	<input checked="" type="checkbox"/> Will any of the following take place during the simulation: custom device created, contrast utilized, or custom blocking determined?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Proton</b>		
<input checked="" type="checkbox"/> Please select treatment type: <input type="checkbox"/> Electron <input type="checkbox"/> Superficial/Orthovoltage/ Supervoltage		
<input checked="" type="checkbox"/> Will an isodose plan be created? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<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		
<b>IMRT Only</b>		
<input checked="" type="checkbox"/> Will the IMRT course of therapy be inversely planned? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Note:</b> 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.		
<input type="checkbox"/> <b>IGRT Technique</b>	<input type="checkbox"/> None (select none for port films)	<input type="checkbox"/> CT Guidance (Conebeam CT)
		<input type="checkbox"/> Stereoscopic Guidance (kV or mV with fiducial markers)
<input checked="" type="checkbox"/> At what frequency will the IGRT be performed? <input type="checkbox"/> Daily <input type="checkbox"/> 1 time per week <input type="checkbox"/> Other _____		
<input type="checkbox"/> <b>Stereotactic Body RT (SBRT)</b>	<input checked="" type="checkbox"/> Fractions: _____	<input checked="" type="checkbox"/> Number of ports/arcs/fields: _____
<input checked="" type="checkbox"/> Which technique will be used?	<input type="checkbox"/> Robotic -Linac Multi-Angle	<input type="checkbox"/> Robotic- Tomotherapy
	<input type="checkbox"/> Non-Robotic – Linac Multi-Angle	<input type="checkbox"/> Non-Robotic - Tomotherapy
		<input type="checkbox"/> Robotic -Cyberknife
		<input type="checkbox"/> Non-Robotic – Gamma Knife



Initial Treatment Phase – Select Therapy - Continued

High Dose Rate (HDR) Brachytherapy Fractions: \_\_\_\_\_

- ✓ Will IGRT be performed?  Yes  No
- ✓ Will a tumor volume and at least one critical structure be contoured?  Yes  No
- ✓ Type of HDR:  Superficial  Electronic  Interstitial

Low Dose Rate (LDR) Brachytherapy ✓ Fractions: \_\_\_\_\_

- ✓ Will a tumor volume and at least one critical structure be contoured?  Yes  No

Boost Phase 1 – Select Therapy

2-Dimension ✓ Fractions: \_\_\_\_\_

3D Conformal ✓ Number of ports/arcs/fields: \_\_\_\_\_

IMRT ✓ Will a new CT be performed?  Yes  No  NA

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

IGRT Technique  None (select none for port films)  CT Guidance (Conebeam CT)  Stereoscopic Guidance (kV or mV with fiducial markers)

- ✓ At what frequency will the IGRT be performed?  Daily  1 time per week  Other \_\_\_\_\_

Boost Phase 2 – Select Therapy

2-Dimension ✓ Fractions: \_\_\_\_\_

3D Conformal ✓ Number of ports/arcs/fields: \_\_\_\_\_

IMRT ✓ Will a new CT be performed?  Yes  No  NA

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

IGRT Technique  None (select none for port films)  CT Guidance (Conebeam CT)  Stereoscopic Guidance (kV or mV with fiducial markers)

- ✓ At what frequency will the IGRT be performed?  Daily  1 time per week  Other \_\_\_\_\_