



Prostate Cancer Radiation Therapy Treatment Plan Checklist

NIA Magellan 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:	Radiation Treatment Facility:	
Treatment Planning Start Date: (i.e., Initial Simulation):		Anticipated Treatment Start Date:
Patient Clinical Information		
<input checked="" type="checkbox"/> Treatment Intent: <input type="checkbox"/> Primary Therapy <input type="checkbox"/> Adjuvant – Post-Prostatectomy <input type="checkbox"/> Palliative		
For Primary Therapy		
T Stage: <input type="checkbox"/> TX <input type="checkbox"/> T0 <input type="checkbox"/> T1 <input type="checkbox"/> T1a <input type="checkbox"/> T1b <input type="checkbox"/> T1c <input type="checkbox"/> T2 <input type="checkbox"/> T2a <input type="checkbox"/> T2b <input type="checkbox"/> T2c <input type="checkbox"/> T3 <input type="checkbox"/> T3a <input type="checkbox"/> T3b <input type="checkbox"/> T4	Does patient have distant metastasis (M1)? <input type="checkbox"/> Yes <input type="checkbox"/> No Gleason Score:	PSA Levels: <input checked="" type="checkbox"/> Most recent PSA Level (ng/ml): <input checked="" type="checkbox"/> Date of this result: <input checked="" type="checkbox"/> PSA Density (ng/ml) (optional) Biopsy Cores: (optional) <input checked="" type="checkbox"/> Number of positive biopsy cores? <input checked="" type="checkbox"/> Percentage of cancer in each core?
ADT (Androgen Deprivation Therapy): <input type="checkbox"/> None <input type="checkbox"/> Short-term (4-6 months) <input type="checkbox"/> Long-term (2+yrs) (optional)		
For Post Prostatectomy: <input checked="" type="checkbox"/> Most recent PSA Level (ng/ml): <input checked="" type="checkbox"/> Date of this result:		
If post-prostatectomy, are any of the following applicable? <input type="checkbox"/> Not Applicable <input type="checkbox"/> Gross Positive Margins <input type="checkbox"/> Seminal Vesicle Invasion <input type="checkbox"/> Extracapsular Extension <input type="checkbox"/> Detectable PSA or initially undetectable PSA but with recent detectable and rising values on 2 or more measurements with no evidence of metastatic disease.		
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: _____		
IMRT ONLY:		
<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		
SRS/SBRT ONLY:		
<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		
IGRT: <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: _____	
IMRT ONLY:	
✓ 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	
SRS/SBRT ONLY:	
✓ 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	
IGRT: <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: _____	
IMRT ONLY:	
✓ 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	
SRS/SBRT ONLY:	
✓ 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	
IGRT: <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	