

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 toll free number.

Please **do not fax** the checklist to NIA Magellan.

General Information		
Patient Name :	DOB:	Health Plan ID :
Radiation Oncologist :	Breast Surgeon :	
Radiation Therapy 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"/> Curative <input type="checkbox"/> Palliative		
<input checked="" type="checkbox"/> Treatment Timing : <input type="checkbox"/> Post-Lumpectomy <input type="checkbox"/> Post-Mastectomy <input type="checkbox"/> Other		
T Stage: <input type="checkbox"/> TX <input type="checkbox"/> Tis (DCIS) <input type="checkbox"/> Tis (LCIS) <input type="checkbox"/> T1 <input type="checkbox"/> T2 <input type="checkbox"/> T3 <input type="checkbox"/> T4	N Stage: <input type="checkbox"/> NX <input type="checkbox"/> N0 <input type="checkbox"/> N2 <input type="checkbox"/> N1 <input type="checkbox"/> N3 Does patient have distant metastasis (M1)? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Breast Being Treating: <input type="checkbox"/> Right Breast <input type="checkbox"/> Left Breast <input checked="" type="checkbox"/> Area Being Treated: <input type="checkbox"/> Whole Breast <input type="checkbox"/> Partial Breast <input type="checkbox"/> Chest Wall <input checked="" type="checkbox"/> Is this a recurrent tumor? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Lymph Node Involvement: <input type="checkbox"/> None <input type="checkbox"/> Regional <input type="checkbox"/> Sentinel <input type="checkbox"/> Both Regional/Sentinel <input checked="" type="checkbox"/> Margin Status: <input type="checkbox"/> Negative <input type="checkbox"/> Close <input type="checkbox"/> Positive <input checked="" type="checkbox"/> Is nodal radiation planned? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Has patient received pre-operative chemotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> For APBI Only <input checked="" type="checkbox"/> Tumor Size (cm): <input checked="" type="checkbox"/> Clinically Unifocal Tumor: <input checked="" type="checkbox"/> BRCA 1 or 2 Mutation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Treatment Planning Information		
<input checked="" type="checkbox"/> What is the prescription radiation dose for the ENTIRE course of external beam treatment?		Gy
Initial Phase	Boost 1 Phase	Boost 2 Phase
<input type="checkbox"/> 2-Dimension	<input checked="" type="checkbox"/> Fractions: _____	
<input type="checkbox"/> 3D Conformal	<input checked="" type="checkbox"/> Number of ports/arcs/fields: _____	
<input type="checkbox"/> IMRT	<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	
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 <input checked="" type="checkbox"/> Will the IMRT course of therapy be inversely planned? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Will techniques to account for respiratory motion be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No Note: IMRT treatment requests will be reviewed for medical necessity by a radiation oncologist. Clinical rationale for performing IMRT is required and should include a comparison 3D-CRT plan, tissue constraints and target goals of the plan and evidence of inverse planning. Field in field or forward planning is not considered IMRT	
<input type="checkbox"/> High Dose Rate (HDR) Brachytherapy	<input checked="" type="checkbox"/> Fractions: _____	
<input checked="" type="checkbox"/> Will a tumor volume and at least one critical structure be contoured? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input checked="" type="checkbox"/> HDR Image Guidance Technique: <input type="checkbox"/> None <input type="checkbox"/> CT Guidance <input type="checkbox"/> X-ray films <input type="checkbox"/> Ultrasound		
<input type="checkbox"/> IGRT Technique	<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 type="checkbox"/> Other _____	
<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 _____		

Boost Phase 1 – Select Therapy

<input type="checkbox"/> Electron	✓ Fractions: _____
<input type="checkbox"/> Photon (2D or 3D)	✓ Number of ports/arcs/fields: _____
<input type="checkbox"/> IMRT	✓ Will a new CT be performed for boost planning? <input type="checkbox"/> Yes <input type="checkbox"/> No
	✓ Will computer based planning be used for electron plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
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
	✓ Will the IMRT course of therapy be inversely planned? <input type="checkbox"/> Yes <input type="checkbox"/> No
	✓ Will techniques to account for respiratory motion be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> High Dose Rate (HDR)	✓ Fractions: _____
✓ Type of brachytherapy boost : <input type="checkbox"/> Tube and Button <input type="checkbox"/> Intracavitary Applicator <input type="checkbox"/> External Applicator <input type="checkbox"/> Other	
✓ Will a tumor volume and at least one critical structure be contoured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
✓ HDR Image Guidance Technique: <input type="checkbox"/> None <input type="checkbox"/> CT Guidance <input type="checkbox"/> Ultrasound <input type="checkbox"/> X-ray films	
<input type="checkbox"/> IGRT Technique	<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 type="checkbox"/> Other _____
✓ At what frequency will the 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"/> Electron	✓ Fractions: _____
<input type="checkbox"/> Photon (2D or 3D)	✓ Number of ports/arcs/fields: _____
<input type="checkbox"/> IMRT	✓ Will a new CT be performed for boost planning? <input type="checkbox"/> Yes <input type="checkbox"/> No
	✓ Will computer based planning be used for electron plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
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
	✓ Will the IMRT course of therapy be inversely planned? <input type="checkbox"/> Yes <input type="checkbox"/> No
	✓ Will techniques to account for respiratory motion be performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> High Dose Rate (HDR)	✓ Fractions: _____
✓ Type of brachytherapy boost : <input type="checkbox"/> Tube and Button <input type="checkbox"/> Intracavitary Applicator <input type="checkbox"/> External Applicator <input type="checkbox"/> Other	
✓ Will a tumor volume and at least one critical structure be contoured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
✓ HDR Image Guidance Technique: <input type="checkbox"/> None <input type="checkbox"/> CT Guidance <input type="checkbox"/> Ultrasound <input type="checkbox"/> X-ray films	
<input type="checkbox"/> IGRT Technique	<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 type="checkbox"/> Other _____
✓ At what frequency will the IGRT be performed? <input type="checkbox"/> Daily <input type="checkbox"/> 1 time per week <input type="checkbox"/> Other _____	

IMRT Note: IMRT treatment requests will be reviewed for medical necessity by a radiation oncologist. Clinical rationale for performing IMRT is required and should include a comparison 3D-CRT plan, tissue constraints and target goals of the plan and evidence of inverse planning.

Special Services – Please note if you are faxing additional information	
<input type="checkbox"/>	Special Dosimetry (CPT® 77331) Provide requested quantity and the rationale for performing the service
<input type="checkbox"/>	Special Physics Consultation (CPT® 77370) Provide the rationale for performing the service.
<input type="checkbox"/>	Special Treatment Procedure (CPT® 77470) Provide the rationale for performing the service.