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 toll free number. Please **do not fax** the checklist to NIA.

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 ___
- ✓ **Is this a new diagnosis of Brain Metastasis?** ☐ Yes ☐ No ☐ Unknown
- ✓ **What is the location of the brain metastasis?** _____
- ✓ **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:** _____
- ✓ **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, e.g., light house work, office work
  - ☐ 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 beamtreatment?** **Gy**

Initial Treatment Phase – Select Therapy

☐ **2-Dimension**
☐ **3D Conformal**
☐ **IMRT**
☐ **Proton**

✓ Fractions: _____
✓ Number of ports/arcs/fields: _____
✓ Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking ☐ Yes ☐ No

IMRT Only
✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Compensator-Based ☐ Helical
✓ Will the IMRT course of therapy be inversely planned? ☐ Yes ☐ No

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✓ ✓

Continued… Initial Treatment Phase			
☐ **Stereotactic Body RT (SBRT)**	✓ Fractions: _____	✓ Number of ports/arcs/fields:	
✓ Which technique will	☐ Robotic -Linac Multi- ☐ Non-Robotic – Linac	☐ Robotic- ☐ Non–Robotic -	☐ Robotic -Cyberknife ☐ Non–Robotic –
☐ **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 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
_____			

Special Services – Please note if you are faxing additional information
☐ **Special Dosimetry (CPT® 77331)** Provide requested quantity and the rationale for performing the service.
☐ **Special Physics Consultation (CPT® 77370)** Provide the rationale for performing the service.
☐ **Special Treatment Procedure (CPT® 77470)** Provide the rationale for performing the service.