

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 :	Breast Surgeon :	
Radiation Therapy Facility :		
Treatment Planning Start Date (i.e. Initial Simulation):	Anticipated Treatment Start Date:	
Patient Clinical Information		
✓ Type of tumor being treated: _____ ✓ Treatment intent/timing: <input type="checkbox"/> Primary <input type="checkbox"/> Adjuvant radiation therapy <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ ✓ Recurrent tumor: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Treatment Planning Information		
✓ What is the prescription radiation dose for the ENTIRE 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: 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 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.		
SRS/SBRT ONLY: Which technique will be used? <input type="checkbox"/> Robotic Linac Multi-Angle <input type="checkbox"/> Robotic - Tomotherapy <input type="checkbox"/> Robotic - CyberKnife <input type="checkbox"/> Non-Robotic - Linac Multi-Angle <input type="checkbox"/> Non-Robotic - Tomotherapy <input type="checkbox"/> Non-Robotic - Gamma Knife <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____		

Boost Phase 1 – 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"/> Electron	<input type="checkbox"/> HDR Brachy	<input type="checkbox"/> LDR Brachy	<input type="checkbox"/> Other _____	

Fractions: _____

IMRT ONLY:

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

Note: IMRT treatment requests may 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.

SRS/SBRT ONLY:

Which technique will be used?

<input type="checkbox"/> Robotic Linac Multi-Angle	<input type="checkbox"/> Robotic - Tomotherapy	<input type="checkbox"/> Robotic - CyberKnife
<input type="checkbox"/> Non-Robotic - Linac Multi-Angle	<input type="checkbox"/> Non-Robotic - Tomotherapy	<input type="checkbox"/> Non-Robotic - Gamma Knife
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____	

LDR ONLY:

If any portion of the patient's radiation oncology treatment will be performed in a facility or hospital other than the facility previously stated, what is the name of that facility? _____

Which portion of the treatment will be performed at the additional facility? NA Initial Phase Boost Phase

Boost Phase 2 – 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"/> Electron	<input type="checkbox"/> HDR Brachy	<input type="checkbox"/> LDR Brachy	<input type="checkbox"/> Other _____	

Fractions: _____

IMRT ONLY:

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

Note: IMRT treatment requests may 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.

SRS/SBRT ONLY:

Which technique will be used?

<input type="checkbox"/> Robotic Linac Multi-Angle	<input type="checkbox"/> Robotic - Tomotherapy	<input type="checkbox"/> Robotic - CyberKnife
<input type="checkbox"/> Non-Robotic - Linac Multi-Angle	<input type="checkbox"/> Non-Robotic - Tomotherapy	<input type="checkbox"/> Non-Robotic - Gamma Knife
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____	

LDR ONLY:

If any portion of the patient's radiation oncology treatment will be performed in a facility or hospital other than the facility previously stated, what is the name of that facility? _____

Which portion of the treatment will be performed at the additional facility? NA Initial Phase Boost Phase