Cervical 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 :	Breast Surgeon :	
Radiation Therapy Facility :		
Treatment Planning Start Date (i.e. Initial Simulation):	Anticipated Treatment Start Date:	

Patient Clinical Information

✓ **Treatment Timing :** ☐ Definitive (Primary) ☐ Pre-Operative ☐ Post-Operative

✓ **FIGO Stage:** ☐ Stage IA1 ☐ Stage IA2 ☐ Stage IB1 ☐ Stage IB2 ☐ Stage IIA ☐ Stage IIB ☐ Stage IIIA ☐ Stage IVA

✓ **Tumor size in centimeters (cm):** _____

✓ **Deep cervical stromal invasion:** ☐Yes ☐No ☐Unknown

✓ **Lymphovascular space invasion:** ☐Yes ☐No ☐Unknown ☐N/A

✓ **Positive pelvic nodes:** ☐Yes ☐No ☐Unknown

✓ **Positive paraaortic nodes:** ☐Yes ☐No ☐Unknown

✓ **Parametrial invasion:** ☐Yes ☐No ☐Unknown

✓ **Distant metastasis:** ☐Yes ☐No ☐Unknown

✓ **Palliative treatment:** ☐Yes ☐No ☐Unknown

✓ **Reason for palliative treatment:** _____

✓ **Previous radiation for cervical cancer:** ☐Yes ☐No ☐Unknown

✓ **Concurrent chemotherapy:** ☐Yes ☐No ☐Unknown

Treatment Planning Information

✓ **What is the prescription radiation dose for the ENTIRE course of external beam treatment?** **Gy**

Initial Treatment Phase – Select Therapy

☐ **2-Dimension** ☐ **3D Conformal** ☐ **IMRT** ☐ **SRS/SBRT** ☐ **Proton**

☐ **HDR Brachytherapy** ☐ **LDR Brachytherapy** ☐ **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?

☐Robotic Linac Multi-Angle ☐ Robotic - Tomotherapy ☐ Robotic - CyberKnife

☐ Non-Robotic - Linac Multi-Angle ☐ Non-Robotic - Tomotherapy ☐ Non-Robotic - Gamma Knife

☐Unknown ☐Other _____

Boost Phase 1 – Select Therapy

☐ **2-Dimension** ☐ **3D Conformal** ☐ **IMRT** ☐ **SRS/SBRT** ☐ **Proton**
☐ **Electron** ☐ **HDR Brachy** ☐ **LDR Brachy** ☐ **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?

☐Robotic Linac Multi-Angle ☐ Robotic - Tomotherapy ☐ Robotic - CyberKnife
☐ Non-Robotic - Linac Multi-Angle ☐ Non-Robotic - Tomotherapy ☐ Non-Robotic - Gamma Knife
☐Unknown ☐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

☐ **2-Dimension** ☐ **3D Conformal** ☐ **IMRT** ☐ **SRS/SBRT** ☐ **Proton**
☐ **Electron** ☐ **HDR Brachy** ☐ **LDR Brachy** ☐ **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?

☐Robotic Linac Multi-Angle ☐ Robotic - Tomotherapy ☐ Robotic - CyberKnife
☐ Non-Robotic - Linac Multi-Angle ☐ Non-Robotic - Tomotherapy ☐ Non-Robotic - Gamma
☐Unknown ☐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