NIA Magellan℠

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

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

✓ Treatment Intent : ☐ Primary Therapy ☐ Adjuvant – Post-Prostatectomy ☐ Palliative

For Primary Therapy

T Stage:	Does patient have distant metastasis (M1)?	PSA Levels :
☐ TX ☐ T0 ☐ T1 ☐ T1a ☐ T1b ☐ T1c ☐ T2 ☐ T2a ☐ T2b ☐ T2c ☐ T3 ☐ T3a ☐ T3b ☐ T4	☐ Yes ☐ No Gleason Score:	✓ Most recent PSA Level (ng/ml): ✓ Date of this result: ✓ PSA Density (ng/ml) (optional) Biopsy Cores: (optional) ✓ Number of positive biopsy cores? ✓ Percentage of cancer in each core?

ADT (Androgen Deprivation Therapy): ☐ None ☐ Short-term (4-6 months) ☐ Long-term (2+yrs) (optional)

For Post Prostatectomy : ✓ Most recent PSA Level (ng/ml): ✓ Date of this result:

If post-prostatectomy, are any of the following applicable?

☐ Not Applicable ☐ Gross Positive Margins
☐ Seminal Vesicle Invasion ☐ Extracapsular Extension
☐ 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

✓ **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 _____

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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