

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		
<input checked="" type="checkbox"/> Treatment Intent : <input type="checkbox"/> Pre Operative <input type="checkbox"/> Post Operative- Adjuvant <input type="checkbox"/> Primary Therapy- No Surgery <input type="checkbox"/> Palliative		
T Stage: <input type="checkbox"/> TX <input type="checkbox"/> T0 <input type="checkbox"/> Tis <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"/> N1 <input type="checkbox"/> N2 Does patient have distant metastasis (M1)? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> If palliative, what is the reason for radiation therapy? (e.g. bleeding, pain, etc.) <input checked="" type="checkbox"/> Margin Status: (Post Operative Only) <input type="checkbox"/> Negative <input type="checkbox"/> Close <input type="checkbox"/> Positive <input type="checkbox"/> Not Applicable <input checked="" type="checkbox"/> Are you treating a recurrent tumor: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Is chemotherapy planned : <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Treatment Planning Information	
<input checked="" type="checkbox"/> 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?
 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 _____	

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