NIA Magellan℠

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

Patient Clinical Information

✓ **Treatment Intent :** ☐ Curative ☐ Palliative

✓ **Treatment Timing :** ☐ Post-Lumpectomy ☐ Post-Mastectomy ☐ Other

T Stage:
☐ TX
☐ Tis (DCIS)
☐ Tis (LCIS)
☐ T1
☐ T2
☐ T3
☐ T4

N Stage:
☐ NX
☐ N0 ☐ N2
☐ N1 ☐ N3

Does patient have distant metastasis (M1)?
☐ Yes ☐ No

✓ **Breast Being Treating:** ☐ Right Breast ☐ Left Breast

✓ **Area Being Treated:** ☐ Whole Breast ☐ Partial Breast ☐ Chest Wall

✓ **Is this a recurrent tumor?** ☐ Yes ☐ No

✓ **Lymph Node Involvement:** ☐ None ☐ Regional ☐ Sentinel ☐ Both Regional/Sentinel

✓ **Margin Status:** ☐ Negative ☐ Close ☐ Positive

✓ **Is nodal radiation planned?** ☐ Yes ☐ No

✓ **Has patient received pre-operative chemotherapy:** ☐ Yes ☐ No

For APBI Only

✓ **Tumor Size (cm):**

✓ **Clinically Unifocal Tumor:** ☐ Yes ☐ No

✓ **BRCA 1 or 2 Mutation:** ☐ Yes ☐ No ☐ NA

Treatment Planning Information

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

Initial Phase	Boost 1 Phase	Boost 2 Phase

☐ **2-Dimension**

✓ Fractions: _____

☐ **3D Conformal**

✓ Number of ports/arcs/fields: _____

☐ **IMRT**

✓ Will any of the following take place during the simulation: custom device created, contrast utilized or custom blocking determined? ☐ Yes ☐ No

IMRT Only

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

✓ Will the IMRT course of therapy be inversely planned? ☐ Yes ☐ No

✓ Will techniques to account for respiratory motion be performed? ☐ Yes ☐ No

Note**: IMRT treatment requests will 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

☐ **High Dose Rate (HDR) Brachytherapy**

✓ Fractions: _____

✓ Will a tumor volume and at least one critical structure be contoured? ☐ Yes ☐ No

✓ HDR Image Guidance Technique: ☐ None ☐ CT Guidance ☐ X-ray films ☐ Ultrasound

☐ **IGRT Technique**

☐ None (select none for port films) ☐ CT Guidance (Conebeam CT) ☐ Stereoscopic Guidance (kV or mV with fiducial markers) ☐ Other _____

✓ At what frequency will the IGRT be performed? ☐ Daily ☐ 1 time per week ☐ Other _____

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Boost Phase 1 – Select Therapy		
☐ **Electron**	✓ Fractions: _____	
☐ **Photon (2D or 3D)**	✓ Number of ports/arcs/fields: _____	
☐ **IMRT**	✓ Will a new CT be performed for boost planning?	☐ Yes ☐ No
	✓ Will computer based planning be used for electron plan?	☐ Yes ☐ No ☐ NA
IMRT Only	✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Compensator-Based ☐ Helical ☐ Arc Therapy ☐ Other	
	✓ Will the IMRT course of therapy be inversely planned?	☐ Yes ☐ No
	✓ Will techniques to account for respiratory motion be performed?	☐ Yes ☐ No
☐ **High Dose Rate (HDR)**	✓ Fractions: _____	
✓ Type of brachytherapy boost : ☐ Tube and Button ☐ Intracavitary Applicator ☐ External Applicator ☐ Other		
✓ Will a tumor volume and at least one critical structure be contoured?		☐ Yes ☐ No
✓ HDR Image Guidance Technique: ☐ None ☐ CT Guidance ☐ Ultrasound ☐ X-ray films		
☐ **IGRT Technique**	☐ None (select none for port films) ☐ CT Guidance (Conebeam CT) ☐ Stereoscopic Guidance (kV or mV with fiducial markers) ☐ Other _____	
✓ At what frequency will the IGRT be performed? ☐ Daily ☐ 1 time per week ☐ Other _____		

Boost Phase 2 – Select Therapy		
☐ **Electron**	✓ Fractions: _____	
☐ **Photon (2D or 3D)**	✓ Number of ports/arcs/fields: _____	
☐ **IMRT**	✓ Will a new CT be performed for boost planning?	☐ Yes ☐ No
	✓ Will computer based planning be used for electron plan?	☐ Yes ☐ No ☐ NA
IMRT Only	✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Compensator-Based ☐ Helical ☐ Arc Therapy ☐ Other	
	✓ Will the IMRT course of therapy be inversely planned?	☐ Yes ☐ No
	✓ Will techniques to account for respiratory motion be performed?	☐ Yes ☐ No
☐ **High Dose Rate (HDR)**	✓ Fractions: _____	
✓ Type of brachytherapy boost : ☐ Tube and Button ☐ Intracavitary Applicator ☐ External Applicator ☐ Other		
✓ Will a tumor volume and at least one critical structure be contoured?		☐ Yes ☐ No
✓ HDR Image Guidance Technique: ☐ None ☐ CT Guidance ☐ Ultrasound ☐ X-ray films		
☐ **IGRT Technique**	☐ None (select none for port films) ☐ CT Guidance (Conebeam CT) ☐ Stereoscopic Guidance (kV or mV with fiducial markers) ☐ Other _____	
✓ At what frequency will the IGRT be performed? ☐ Daily ☐ 1 time per week ☐ Other _____		

IMRT Note: *IMRT treatment requests will 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.*

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.