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:
☐ TX
☐ T0
☐ T1 ☐ T1a ☐ T1b ☐ T1c
☐ T2 ☐ T2a ☐ T2b ☐ T2c
☐ T3 ☐ T3a ☐ T3b
☐ T4

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

Gleason Score:

PSA Levels :
✓ 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** ✓ Fractions: _____

☐ **3D Conformal** ✓ Number of ports/arcs/fields: _____

☐ **IMRT**

☐ **SBRT**

✓ 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 IMRT course of therapy be inversely planned? ☐ Yes ☐ No ✓ Techniques to account for respiratory motion ☒ NA

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.

SBRT Only ✓ Which technique will be used? ☐ Robotic –Linac Multi-Angle ☐ Robotic- Tomotherapy ☐ Robotic –Cyberknife ☐ Non –Robotic

☐ **Low –Dose Rate (LDR) Brachytherapy – Seed Implant**

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

Note*: Two brachytherapy isodose plans will be approved for all prostate seed implants (1 for the pre-plan or day-of plan & 1 for the post-plan). If "yes" is answered to the question above, 77295 will be substituted for one 77318.*

☐ **High Dose Rate (HDR) Brachytherapy** ✓ Fractions: _____

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

☐ **IGRT** ☐ None (No IGRT, port films only) ☐ CT Guidance (Conebeam CT) ☐ Stereoscopic Guidance (kV/mV w/ fiducial markers) ☐ Ultrasound ☐ Other _____

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

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Boost Phase 1 – Select Therapy

☐ **2-Dimension** ✓ Fractions: _____

☐ **3D Conformal** ✓ Number of ports/arcs/fields: _____

☐ **IMRT**

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

☐ **Low -Dose Rate (LDR) Brachytherapy - Seed Implant**

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

✓ 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?

☐ **High Dose Rate (HDR) Brachytherapy** Fractions: _____

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

☐ **IGRT Technique** ☐None (No IGRT, port films only) ☐CT Guidance (Conebeam CT) ☐ Stereoscopic Guidance (kV/mV w/ fiducials) ☐ Ultrasound ☐ Other _____

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

Boost Phase 2 – Select Therapy

☐ **2-Dimension** ✓ Fractions: _____

☐ **3D Conformal** ✓ Number of ports/arcs/fields: _____

☐ **IMRT**

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

☐ **Low -Dose Rate (LDR) Brachytherapy - Seed Implant**

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

✓ 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?

☐ **High Dose Rate (HDR) Brachytherapy** Fractions: _____

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

☐ **IGRT Technique** ☐None (No IGRT, port films only) ☐CT Guidance (Conebeam CT) ☐ Stereoscopic Guidance (kV/mV w/ fiducials) ☐ Ultrasound ☐ Other _____

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

***Note**: Two brachytherapy isodose plans will be approved for all prostate seed implants (1 for the pre-plan or day-of plan & 1 for the post-plan). If "yes" is answered to the question above, 77295 will be substituted for one 77318.*

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.