

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		
✓ Site of primary cancer: <input type="checkbox"/> Breast <input type="checkbox"/> Prostate <input type="checkbox"/> Lung <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown		
✓ How many sites are being treated: <input type="checkbox"/> Single Site <input type="checkbox"/> Two or More Sites <input type="checkbox"/> Unknown		
✓ Location of the bone mets being treated: <input type="checkbox"/> Spine <input type="checkbox"/> Femur <input type="checkbox"/> Pelvis <input type="checkbox"/> Rib <input type="checkbox"/> Humerus <input type="checkbox"/> Shoulder <input type="checkbox"/> Skull <input type="checkbox"/> Other _____		
✓ Reason for treatment (e.g. pain, spinal cord compression, etc): _____		
✓ List other sites with metastatic disease: _____		
✓ What is the patient's performance status? (ECOG Scale)		
<input type="checkbox"/> 0 – Fully active, able to carry on all pre-disease performance without restriction		
<input type="checkbox"/> 1 – Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work		
<input type="checkbox"/> 2 – Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours		
<input type="checkbox"/> 3 – Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours		
<input type="checkbox"/> 4 – Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair		
✓ Has patient had prior radiation for bone metastasis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Treatment Planning Information		
✓ 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? <input type="checkbox"/> Linac Multi-Angle <input type="checkbox"/> Compensator-Based <input type="checkbox"/> Helical <input type="checkbox"/> Arc Therapy <input type="checkbox"/> Other		
<u>Note:</u> 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