Hodgkin's Lymphoma Radiation Therapy Treatment Plan Checklist

1/1/2015

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

- ✓ **Location of the tumor being treated:** _____
- ✓ **Number of sites being treated:** _____
- ✓ **Treated for Lymphocyte Predominant Hodgkin's Lymphoma:** ☐Yes ☐No ☐Unknown
- ✓ **Treatment timing :** ☐ Definitive ☐ Adjuvant ☐ Recurrent/Relapse ☐ Other _____
- ✓ **Treatment Intent :** ☐ Curative ☐ Palliative ☐ Unknown
- ✓ **Stage :** ☐ Stage I ☐ Stage IB ☐ Stage II ☐ Stage IIB ☐ Stage III ☐ Stave IV
- ✓ **Bulky disease:** ☐Yes ☐No ☐Unknown
- ✓ **Receive chemotherapy or chemotherapy planned:** ☐Yes ☐No ☐Unknown
- ✓ **Previous radiation treatment for Hodgkin's:** ☐Yes ☐No ☐Unknown

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**

- ✓ Fractions: _____
- ✓ Number of ports/arcs/fields: _____
- ✓ 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

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.*

☐ **IGRT Technique** ☐None (select none for port films) ☐CT Guidance (Conebeam CT) ☐ Stereoscopic Guidance (kV or mV with fiducial markers)

- ✓ 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** ✓ Will a new CT be performed? ☐ Yes ☐ No ☐ NA

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

☐ **IGRT Technique** ☐None (select none for port films) ☐CT Guidance (Conebeam CT) ☐ Stereoscopic Guidance (kV or mV with fiducial markers)

✓ 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** ✓ Will a new CT be performed? ☐ Yes ☐ No ☐ NA

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

☐ **IGRT Technique** ☐None (select none for port films) ☐CT Guidance (Conebeam CT) ☐ Stereoscopic Guidance (kV or mV with fiducial markers)

✓ 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.