Anal Cancer 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

T Stage:
- ☐ TX
- ☐ T0
- ☐ Tis
- ☐ T1
- ☐ T2
- ☐ T3
- ☐ T4

N Stage:
- ☐ NX ☐ N0
- ☐ N1 ☐ N2

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

- ✓ **Treatment Intent :** ☐ Curative ☐ Palliative
- ✓ **Reason for palliative treatment:** _____
- ✓ **Treatment Timing :** ☐ Primary ☐ Pre-Operative ☐ Post-Operative
- ✓ **Margin Status:** ☐ Positive ☐ Negative ☐ Close ☐ Not Applicable
- ✓ **Is this a recurrent tumor?** ☐ Yes ☐ No
- ✓ **Is chemotherapy planned:** ☐ Yes ☐ No

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

☐ **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

☐ **Low Dose Rate (LDR) Brachytherapy**

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

☐ **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 _____
☐ **High Dose Rate (HDR)** ☐ **Low Dose Rate (LDR)** ✓ Fractions: _____
✓ Image Guidance Technique: ☐ None ☐ CT Guidance ☐ Ultrasound ☐ X-ray films

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 _____
☐ **High Dose Rate (HDR)** ☐ **Low Dose Rate (LDR)** ✓ Fractions: _____
✓ Image Guidance Technique: ☐ None ☐ CT Guidance ☐ Ultrasound ☐ X-ray films

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.