Non- Small Cell Lung 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 :	Radiation Therapy Facility :	
Treatment Planning Start Date (i.e. Initial Simulation) :	Anticipated Treatment Start Date :	

Patient Clinical Information

✓ **Treatment Intent :** ☐ Pre- Operative ☐ Post-Operative – Adjuvant ☐ Primary Therapy- Inoperable ☐ Palliative

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

N Stage:
☐ NX
☐ N0 ☐ N2
☐ N1 ☐ N3

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

✓ If palliative, what is the reason for radiation therapy? (e.g. airway obstruction, hemoptysis pain, etc.)

✓ Margin Status (Post Operative Only): ☐ Negative ☐ Close ☐ Positive ☐ N/A

✓ Is there extracapsular nodal extension? ☐ 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 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 and tissue constraints and target goals of the plan. Field in field or forward planning is not considered IMRT.*

☐ **SBRT**

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

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

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

✓ Fractions: _____

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

☐ **Image Guidance (IGRT) Technique:** ☐ None (select none for port films) ☐ CT Guidance (Conebeam CT) ☐ Stereoscopic Guidance (kV or mV) ☐ 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** ✓ Will a new CT be performed? ☐ Yes ☐ No

IMRT Only
✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Compensator-Based ☐ Helical ☐ Arc Therapy ☐ Other
✓ Will techniques to account for respiratory motion be performed? ☐ Yes ☐ No

☐ **Image Guidance (IGRT) Technique:** ☐ None (select none for port films) ☐ CT Guidance (Conebeam CT) ☐ Stereoscopic Guidance (kV or mV) ☐ 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** ✓ Will a new CT be performed? ☐ Yes ☐ No

IMRT Only
✓ Which technique will be used? ☐ Linac Multi-Angle ☐ Compensator-Based ☐ Helical ☐ Arc Therapy ☐ Other
✓ Will techniques to account for respiratory motion be performed? ☐ Yes ☐ No

☐ **Image Guidance (IGRT) Technique:** ☐ None (select none for port films) ☐ CT Guidance (Conebeam CT) ☐ Stereoscopic Guidance (kV or mV) ☐ Other _____

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

***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 and tissue constraints and target goals of the plan. Field in field or forward planning is not considered IMRT.*

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.