XOFIGO (RADIUM 223 DICHLORIDE) REFERRAL DATA SHEET

Please note new location and contact information for CMIT

Center for Molecular Imaging and Therapy
2120 Kings Highway
Scheduling: 318-716-4001
Fax: 318-716-4075

PATIENT NAME: _____
print

PHYSICIAN: _____ _____
print signature of referring physician

NOTE: THIS REFERRAL COVERS THERAPY CONSISTING OF SIX (6) XOFIGO TREATMENTS AT APPROXIMATELY ONE MONTH INTERVALS

Oncologist please complete the following:
Indication for XOFIGO treatment:_____

If Prostate Cancer:
Does the patient have a confirmed diagnosis of prostate cancer: ☐ Yes ☐ No

Is the disease Castration Resistant (CRPC) or Hormone Refractory (HRPC): ☐ Yes ☐ No

Is the disease bone predominant with no lung, liver, and/or brain metastasis: ☐ Yes ☐ No

Does the patient have at least 2 bone metastases on a bone scan: ☐ Yes ☐ No If yes, Date of scan:_____

Does the patient have symptomatic disease (regular use of analgesics for bone pain or EBRT for bone pain within the last 12 weeks) ☐ Yes ☐ No

Does the patient have a life expectancy of > 6 months: ☐ Yes ☐ No

Does the patient have an Eastern Cooperative Oncology Group (ECOG) Performance Status (PS) of 0-2: ☐ Yes ☐ No

Has the patient had cytotoxic chemotherapy within the last 4 weeks: ☐ Yes ☐ No

Is there any intention to use cytotoxic chemotherapy in the next 6 months: ☐ Yes ☐ No

Has the patient received radiation therapy to > 25% of bone marrow: ☐ Yes ☐ No

Has the patient received pervious radionuclide therapy for bone metastases: ☐ Yes ☐ No

Baseline & Hematological Status:
Age of Patient:_____
Hemoglobin (HB):_____ on _____
Is HB < 10.0 g/dL:_____
PSA Level: _____ ng/ml on _____

Absolute Neutrophil Count (ANC): _____ on _____
Is ANC < 1.5 x 10^9/L: _____
Platelet Count:: _____ on _____

This office has requested pre-authorization for CPT 99205 and 79101 (Qty 6) and HCPCS A9588 (Qty 6).
☐ Yes ☐ No

In order to provide you with the maximum possible information from your patient's PET/CT scan, it is critical that the clinical data on this form be available to the physician at the time of the study. It should be supplemented with copies of an appropriate history and physical or clinical notes, copies of recent diagnostic imaging reports and relevant laboratory data (e.g. tumor marker levels), as well as results of recent biopsy or surgical pathology. **Patients cannot be scheduled without the information on this form being complete and signed by the referring physician (required by CMS (Medicare) and private insurance carriers).**

Person faxing information: _____ **Phone #** _____