UNIVERSITY OF MISSOURI
RADIOPHARMACEUTICAL ADMINISTRATION FORM
Lu-177 Lutathera ONLY

This form shall be used for the administration of Therapeutic dosages of ***Lu-177 Lutathera*** only

RADIOPHARMACEUTICAL PRESCRIPTION:

Lutetium-177 LUTATHERA

(To be completed by authorized physician)

Patient sticker here

To include:

- Patient Name
- DOB
- Hospital ID number

Procedure: *Lutetium-177 Lutathera*
Requesting Physician: _____
Authorizing Physician: _____
Radiopharmaceutical Prescribed: _____

Route of administration: *IV Administration*

Dosage Ordered: _____ mCi

Infusion Cycle Number: _____

Signature of Authorized Physician:

_____Date_____

☐ Written instructions provided.

PRE-ADMINSTRATION

Prior to administering the radiopharmaceutical, the person performing the administration must verify the identity of the patient in the written directive, and that the details of the administration are in accordance with the written directive and approved by Radiation Oncology consult. The person responsible for the administration of the radiopharmaceutical will complete the form.

PATIENT IDENTIFICATION VERIFIED by (2 required):

☐ Name ☐ Hospital I.D.
☐ Date of Birth ☐ Personal Recognition ☐ Photo I.D.

Patient is:

☐ Male ***OR*** (if MALE stop here)
☐ Female (if FEMALE check a box in both sections below)

If Female:

VERIFY PATIENT IS NOT BREAST FEEDING *by:*

☐ Patient has declared not currently breastfeeding

AND

VERIFY PATIENT IS NOT PREGNANT *by:*

☐ Declares menstruating, not pregnant, or to be postmenopausal ***OR***
☐ Negative pregnancy Test ***OR***
☐ Rendered sterile, i.e. Hysterectomy, Tubal Ligation, etc., ***OR***
☐ Verify patients' age is ≤ 8 or ≥ 60 years

RADIOPHARMACEUTICAL DOSAGE VERIFICATION: *(COMPLETED BY PERSON ADMINISTERING RADIOPHARMACEUTICAL)*

Radiopharmaceutical drug being administered: *Lutetium-177 Lutathera*

Radiopharmaceutical Lot Number: _____

Pharmaceutical Company measurement: _____ mCi Date: _____/_____/_____ Time: _____:_____

MU Dose Calibrator measurement: [KK] _____ mCi Date: _____/_____/_____ Time: _____:_____

Route of Administration: *IV Administration*

Lu-177 Lutathera Dose Verification Worksheet attached: ☐ yes ☐no

Pre-/Post-Administration checks performed by signature: _____ Date: _____/_____/_____ Time: _____:_____

RADIOPHARMACEUTICAL INFUSION:

Signature of Individual Administering Dose: _____ Date: _____/_____/_____ Time: _____:_____

IV SITE:_____ ☐Patency Assessment performed

Amino Acid Infusion Start Time: _____:_____ (must be >30minutes prior to Lutathera infusion start time)

Lutathera Infusion Start Time: _____:_____ Lutathera Infusion Completion time: _____:_____

POST-INFUSION:

Note: Revisions must be made, signed, and dated by an AU within 24 hours

Calculated Activity Delivered [DDD] : _____ mCi Percent Prescribed Activity Delivered [EEE] _____%

Emerging patient conditions? ☐ Yes ☐ No

Provide explanation:

_____

_____

_____

Authorized User Signature: _____ Date: _____/_____/_____

Comments/Notes: _____

Patient Released by the Following Criteria

☐ Patient reading at 1 m is <8.6mR/hr

☐ Patient release instructions given

Released by NM (Signature): _____ Date: _____/_____/_____

Final review by Nuclear Medical Staff (Signature): _____ Date: ___/____/____

RETAIN THIS RECORD FOR 3 YEARS: REQUIRED BY 10 CFR 35.2040