UNIVERSITY OF MISSOURI
RADIOPHARMACEUTICAL ADMINISTRATION FORM
Lu-177 Pluvicto ONLY

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

RADIOPHARMACEUTICAL PRESCRIPTION:

Lutetium-177 PSMA (Pluvicto)

(To be completed by authorized physician)

Patient sticker here

To include:

- Patient Name
- DOB
- Hospital ID number

Procedure: *Lutetium-177 PSMA for Prostate Cancer*

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 Nuclear Medicine/Radiation Oncology consult. The person responsible for the administration of the radiopharmaceutical will review relevant labs to determine that they are satisfactory and complete the form.

PATIENT IDENTIFICATION VERIFIED by (2 required):

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

Patient is:

☐ Male

VERIFY PATIENT:

☐ Patient has consented

AND

☐ Patient had PSMA Scan for Prostate Ca.
☐ Metastatic disease by PSMA Scan
☐ Satisfactory blood counts.

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

Radiopharmaceutical drug being administered: *Lutetium-177 Pluvicto*

Radiopharmaceutical Lot Number: _____

Pharmaceutical Company measurement (Dose Received): _____ mCi Date: _____/_____/_____ Time: _____: _____

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

Route of Administration: *IV Administration*

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

RADIOPHARMACEUTICAL INFUSION:

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

IV SITE: _____ ☐Patency Assessment performed

Pluvicto Infusion Start Time: _____: _____ Pluvicto 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