

## PSMA PET/CT REQUISITION

### Molecular Imaging and Therapy – Vancouver

PET Reception: (604) 707-5951

PET Fax: (604) 877-6245

Current Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

### Clinical Trial Information (if applicable)

Clinical Trial Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### For Department use only

Scan Date: \_\_\_\_\_ Time: \_\_\_\_\_

Indication #: \_\_\_\_\_ 1 ☐ 2 ☐

Details: \_\_\_\_\_

Routine: ☐ V-T: ☐ Other: \_\_\_\_\_

Date: \_\_\_\_\_ PET Dr. Initial: \_\_\_\_\_

### Patient Information

#### Important:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ (kg / lb)

#### Mandatory:

PSA within last 3 months? Value: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Surname First Middle

Date of Birth: D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_ PHN: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Mobile: ( ) \_\_\_\_\_

Temporary Address: \_\_\_\_\_ Temporary Phone: ( ) \_\_\_\_\_

Family Physician: ( ) \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Patient Mobility: Ambulatory ☐ Wheelchair ☐ Stretcher ☐

### Diagnosis/Pertinent History

#### Indication for PSMA PET/CT Imaging (select one or more criteria below 1 - 6):

- ☐ 1) Localized prostate cancer considered for definitive therapy when conventional imaging is equivocal for metastatic disease.
- ☐ 2) NCCN high to very high risk localized prostate cancer with negative conventional imaging prior to consideration of curative intent therapy.
- ☐ 3) Clinically oligometastatic or oligoprogressive disease on prior imaging, being considered for metastases-directed therapy.
- ☐ 4) Localization of biochemical cancer Recurrent (BCR) or Persistent (BCP) prostate cancer following curative-intent therapy in the following settings\*:
- ☐ Pathologically node positive post RP with a PSA > 0.1 ng/mL at least 6 weeks after RP.
  - ☐ BCP with persistently elevated PSA > 0.1 ng/mL on first post RP PSA between 6 weeks and 3 months after Radical Prostatectomy when Gleason Grade Group (ISUP) 4-5.
  - ☐ BCR with a PSA > 0.2 ng/mL more than 6 weeks post Radical Prostatectomy when either PSA doubling time < 12 months OR Gleason Grade Group (ISUP) 4-5.
  - ☐ BCR with a PSA > 0.4 ng/mL more than 6 weeks post Radical Prostatectomy.
  - ☐ BCR post curative intent radiotherapy +/- adjuvant hormone therapy: i.e. a rise in PSA of ≥ 2 ng/mL above nadir.
  - ☐ BCR (Increase in PSA to ≥ 0.4 ng/mL) after prostatectomy and salvage radiotherapy +/- hormone therapy, where there is intent for further salvage therapy (e.g., SABR/metastases directed therapy).

- ☐ 5) **Castration resistant PC with evidence of biochemical or imaging progression.** Treatment does not need to be discontinued before the PET scan. Progression is defined by any of the following: A minimum PSA of 2.0 ng/mL and 2 consecutive rises above the nadir and castrate levels of testosterone (<1.7 nmol/L), soft tissue disease progression on chest, abdomen, pelvis CT or MR (RECIST v1.1), or bone progression  $\geq 2$  new lesions on bone scan.
- ☐ 6) **To determine eligibility for PSMA-targeted radioligand therapy.**
- ☐ 7) **Clinical scenarios not included on this list but deemed appropriate after consensus at an appropriate BC Cancer Tumour Conference which includes expert imaging review. Describe below:**

---



---



---

**\*Notes:** i) Conventional staging should be considered when appropriate in each setting of criteria 4, if the PSA is very high, but is not a requirement prior to requesting PSMA PET.

ii) If the initial PSMA PET is negative, and no treatment is pursued, a second PSMA PET should not be requested for at least 6 months after the first scan unless recommended at appropriate BC Cancer Tumour Conference

### **Essential Information**

Does patient require an interpreter?	Y <input type="checkbox"/> N <input type="checkbox"/>	Language: _____
Does patient have any drug allergies?	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
CT scan within 3 months?	Y <input type="checkbox"/> N <input type="checkbox"/>	Date: _____
MRI scan within 3 months?	Y <input type="checkbox"/> N <input type="checkbox"/>	Date: _____
Nuclear Med scan within 3 months?	Y <input type="checkbox"/> N <input type="checkbox"/>	Date: _____
Previous PET or PET/CT scan?	Y <input type="checkbox"/> N <input type="checkbox"/>	Location/date: _____

**Doctor's Signature:** \_\_\_\_\_ **MSP No:** \_\_\_\_\_

Additional Copies of Report \_\_\_\_\_  
to: