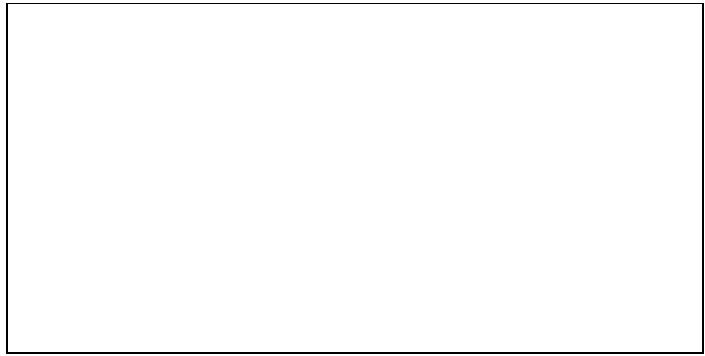




# PLUVICTO

## (177Lu-PSMA) Prescription



Patient's name : \_\_\_\_\_

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

Date of birth : \_\_\_\_\_

\_\_\_\_\_  
Name of prescribing physician

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
DATE

**Tel:** \_\_\_\_\_  
Prescriber's telephone and fax number

**Fax:** \_\_\_\_\_  
Prescriber's email address

VMMED - 2345, Guy street, Montreal, QC, H3H 2L9  
petct@vmmed.com **Tel:** 514-933-5885 **Fax:** 514-933-4646

## Documents to be provided for this request

- The **report by fax or email** of the last PSMA PET scan done within the last **3 months**.
- The **reports by fax or email** of any medical imaging exams done in the **past year** (CT, MRI, PET, Bone scan).
- All images related to the reports mentioned above (**CD, USB key or any secured web access**).
- An **updated** medication list.
- Patient's medical history (short description of any therapy received for prostate cancer).
- Laboratory results done within the last **3 months** (CBC, creatinine, glomerular filtration rate, AST, ALT, alkaline phosphatase, urea, albumin, PSA, testosterone - *at 1st treatment*).