ZEVALIN® (ibritumomab tiuxetan) THERAPY REFERRAL DATA SHEET
Biomedical Research Foundation of Northwest Louisiana
Center for Molecular Imaging and Therapy (CMIT/PET CENTER)
Scheduling Phone: 318-675-4042 Fax: 318-675-4020
Toll Free: 1-888-685-1152

PATIENT NAME: _____
print

PHYSICIAN: _____ _____
print signature of referring physician

NOTE: THIS REFERRAL COVERS THERAPY CONSISTING OF ONE (1) ZEVALIN® Administration

Hematologist/Oncologist please complete the following:
Indication for Zevalin® treatment: _____

Baseline Status
Age of Patient (yrs): _____
- Is Serum Total Bilirubin > 2.0 mg/dL: _____ Sr. Total Bilirubin (value & date): _____
- Is the Serum Creatinine > 2.0 mg/dL: _____ Sr. Creatinine (value & date): _____
- For female patients; Date & result of Serum Pregnancy test (if applicable): _____
- For female patients; Is the patient lactating? YES/NO
- Has the patient had major surgery (other than diagnostic) within four weeks prior to injection? YES/NO
- For patients who have previous exposure to murine antibodies, do they have a positive HAMA? YES/NO

Hematologic Status (All Responses Must be "No")
- Is the ANC $\leq$ 1,500/mm^3? YES/NO ANC (value & date): _____
- Is the platelet count < 100,000/mm^3? YES/NO Platelet Count (value & date): _____
- For patients with small lymphocytic lymphoma, is total lymphocyte count $\geq$ 5,000/mm3? YES/NO
- Has the patient had prior myeloablative therapy with bone marrow transplantation or peripheral blood stem cell rescue? YES/NO
- Does the patient have a history of failed stem cell collection? YES/NO
- Does the patient have $\geq$ 25% bone marrow involvement? (Result to be determined from bone marrow aspirate or biopsy within 6 weeks of injection if indication is not for chemotherapy consolidation) YES/NO
- Does the patient have hypocellular marrow $\leq$ 15% cellularity? YES/NO
- Does the patient have marked reduction in bone marrow precursors of one or more cell lines (granulocytic, megakaryocytic, erythroid)? YES/NO

Previous Anti-Neoplastic Therapy (All Responses Must be "No")
- Has the patient had anti-cancer therapy within the last three weeks? (Six weeks for Rituximab, nitrosurea, or Mitomycin C)? YES/NO
- Has the patient had prior radioimmunotherapy? YES/NO
- Has the patient received external beam irradiation to > 25% of active bone marrow? YES/NO

Please also submit your patient's radiologic and/or nuclear medicine scan results, lab results, and clinical notes with this referral form. ***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 #** _____