

Referral Form

Attention to: Treatment center/contact name: _____

Phone number: _____ Fax: _____

1 Patient Information

Patient name: _____ Date of birth (MM/DD/YYYY): _____

Address: _____

City/State/ZIP: _____

Phone number: _____ Email: _____

2 Referring Provider Information

Provider name: _____ Practice name: _____

Practice address: _____

City/State/ZIP: _____

Office contact information:

Name: _____ Phone number: _____

Email: _____ Fax: _____

3 Insurance Information

Please attach copies of the front and back of insurance card. Select all that apply: ☐ Primary ☐ Secondary

4 Diagnosis and Treatment Information

Primary diagnosis code (include at least 1): _____

Secondary diagnosis code(s) (include at least 1): _____

For a full list of ICD-10 codes, refer to the [PLUVICTO Coding and Billing Guide](#).

Prostate-specific membrane antigen positron emission tomography (PSMA-PET) scan in the last 6 months?

☐ Yes Date: _____ ☐ No

Prior treatments:

☐ Androgen receptor pathway inhibitor (ARPI) ☐ Taxane-based chemotherapy

☐ Other treatments received/failed: _____

Notes:

Once you have completed this form, please share a copy directly with your preferred treatment center.

FOR TREATMENT CENTER USE

Appointment date: _____

Notes: