UW Health
University of Wisconsin Hospital and Clinics

Radiopharmaceutical Therapy Dose Documentation Form
Ra-223 Radium Dichloride (Xofigo®)

A. WRITTEN DIRECTIVE:

1. Pt Name:	2. MR#:	3. Birth Date:
4. Radiopharmaceutical (Including Isotope): **Ra-223 Radium Dichloride (Xofigo®)**		5. Weight (kg):
6. Date of Administration:	7. Time of Administration:	8. Dose (uCi): (1.35 uCi/kg)
9. Referring physician:		
10. Indication: Castration Resistant Prostate Metastases	11. ☐ Initial Dose <or> ☐ Subsequent Dose	
12. ☐ Prior to **first** administration of Xofigo®, -Absolute neutrophil count (ANC) should be ≥1.5 × 10^9/L -Platelet count ≥100 × 10^9/L -Hemoglobin ≥10 g/dL.	13. ☐ Prior to **subsequent** administrations: - Absolute neutrophil count (ANC) should be ≥1 × 10^9/L - Platelet count ≥50 × 10^9/L.	
14. Signature of Authorized MD	15. Date_____& Time_____ Signed	

B. EXPOSURE CALCULATIONS:

Alpha Radiation Administered. Release criteria assessed and met, calculations not required

Verified by (initial): _____	**NOTE: Must NOT be the individual who signed the written directive** Must be Authorized ANP, AU, or AMP

C. PHARMACY COMPUTER ORDER ENTRY DOCUMENTATION:

Completed by (initial): _____	
Verified by (initial): _____	**NOTE: Must NOT be the individual who did the pharmacy computer order entry**

D. DOSE PREPARATION DOCUMENTATION:

Dose Assay: Provided on Cardinal Label	**NOTE: Must NOT be the individual administering the product**	
Dose Assay (uCi) = _____	Assay Date _____ & Time _____	UWHC RX# _____

Verified by (initial): _____	**NOTE: Must NOT be the individual who did the preparation, NOR the one administering**	
Dose Assay (uCi) = _____	Assay Date _____ & Time _____	UWHC RX# _____

E. PATIENT INFORMATION/EDUCATION VERIFICATION: (NOTE: To be completed by the Authorized User)	
Completed by (initial): _____	Pt ID Verification (2 methods used; Name must be 1 of the 2) Verified: Name AND Birthdate <OR> MR#
Completed by (initial): _____	Prescribing physician explained dose and treatment to administering clinician.
Completed by (initial): _____	Negative pregnancy test or excluding clinical condition confirmed with reasonable assurance
Completed by (initial): _____	Patient is not currently breast feeding.
Completed by (initial): _____	Informed consent obtained or verified
Completed by (initial): _____	**Patient Education provided by Authorized User or Authorized Medical Physicist** -Compliance with blood cell count monitoring appointments is necessary. -Stay well hydrated and monitor oral fluid intake and urine output. -Report signs of dehydration, hypovolemia, urinary retention, or renal failure/insufficiency to your physician. -There are no restrictions regarding contact with other people after receiving therapy. -Follow good hygiene practices while receiving Xofigo and for at least 1 week after the last injection. -Caregivers should use universal precautions for patient care. -Use an effective method of birth control during treatment and for 6 months following completion of treatment.

F. ADMINISTRATION VERIFICATION: (NOTE: To be completed at the time of treatment)		
Clinician #1 ⬇	**Clinician #2** ⬇	**Clinician #1** is the Administering Clinician who is giving the dose. **Clinician #2** is NOT administering the dose and did not compound/fill dose
Initial _____	Initial _____	**Clinician #1** reads aloud the patient name, radiopharmaceutical and dose from the product label. **Clinician #2** reviews the written directive and verifies that the following match: Patient Name <and> Radiopharmaceutical <and> Dose
Initial _____	Initial _____	**A**ssay of dose in the dose calibrator Dose Assay (uCi) = _____ Date _____ Time _____
Initial _____	Pt ID Verification (2 methods used; Name must be 1 of the 2) Check: Name AND Birthdate <OR> MR#	
Initial _____	Negative pregnancy test or excluding clinical condition confirmed with reasonable assurance.	
Initial _____	Patient is not currently breast feeding.	
Initial _____	Ra-223 dose administered via peripheral IV placed by Nuclear Medicine or Radiation Oncology slowly over 1 minute	
Initial _____	At least 10 mL sodium chloride 0.9% administered via peripheral IV before and after dose administered to check patency and flush IV system	
Initial _____	Assay of syringe/ Total Dose Administered:(same dose calibrator to be used for both measurements) _____(pre-administered syringe) - _____ ___(post-administered syringe) = _____ If total dose administered is not within 10% of prescribed dose, notify Authorized User	
Initial _____	Patient released at the time of administration	

Clinician #1 Signature _____Date_____ Time_____