Melanoma & Merkel Cell Carcinoma Requisition to PET Centre

TO BE COMPLETED BY THE REFERRING PHYSICIAN

The indications under Section B are part of the Ontario PET Registry. Completion of a post scan form is required following the PET scan. Together the pre and post scan information will provide vital data to build evidence for use of PET for this indication. Accurately complete both the pre and post scan forms.

Referring Physician Name: _____

Physician Phone: (_____) _____ ext. _____ Fax: (_____) _____ CPSO No:_____

Patient Name: _____
SURNAME FIRST NAME MIDDLE

OHIP Number: _____

Telephone: (_____) _____ **Postal Code:** _____

Date of birth: _____/_____/_____ **Gender:** ☐ M ☐ F ☐ Other
YYYY / MM / DD

Relevant Clinical History:

Provide the most recent and relevant imaging report(s) and other relevant clinical history.

The following documents must be attached to this requisition:
☐ Relevant Imaging Studies within the previous 3 months (i.e. CT, US, MR, Other)
☐ Consult Note or Referral Letter; including relevant lab work/pathology, if relevant

Fax Instructions

Please fax the completed request form, along with the required supporting documentation, to the PET Centre of choice for appointment. A complete list of PET Centres and their contact information is available at PET Scan Services in Ontario

Complete EITHER Section A or B ***(not both)***

Section A – PET for the staging of patients with localized "high risk" melanoma OR Merkel Cell Carcinoma, or for the evaluation of patients with isolated metastases, when surgery or other ablative therapies are being considered.

Indication *(choose only one)*

☐ Staging of:
- ☐ Localized high risk melanoma, OR
- ☐ Merkel Cell Carcinoma

(e.g., lymph node metastases, satellitosis or intransit metastases, or deep head & neck melanoma)

☐ Evaluation of isolated metastases

Attach the relevant diagnostic imaging reports (CT, US, MRI) & provide images to PET centre.

Physician Signature: _____ **Date:** _____

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Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@ontariohealth.ca
Document disponible en français en contactant info@ontariohealth.ca

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Complete EITHER Section A or B *(not both)* **Patient Name:**_____

*Section B – PET in Immunotherapy for Metastatic Melanoma OR Merkel Cell Carcinoma

Melanoma
Type of Melanoma:

☐ Cutaneous ☐ Mucosal ☐ Acral Lentiginous
☐ Uveal ☐ Unknown Primary

BRAF Status (Melanoma only):
☐ Wild Type ☐ Mutant
☐ Other molecular change (specify): _____

Current line of Immunotherapy:
☐ First Line ☐ Second Line ☐ Other (specify): _____

Has the patient received prior adjuvant immunotherapy?
☐ Yes ☐ No

Merkel Cell Carcinoma:
Primary Location of Merkel cell carcinoma:

☐ Head & Neck ☐ Trunk ☐ Extremity ☐ Mucosal
☐ Unknown ☐ Other (specify): _____

Polyomavirus IHC:
☐ Present ☐ Absent ☐ Unknown

Current line of Immunotherapy:
☐ First Line ☐ Second Line ☐ Other (specify):_____

Has the patient received prior adjuvant immunotherapy?
☐ Yes ☐ No

Has the patient received prior chemotherapy?
☐ Yes ☐ No

Indication *(choose only one)*

☐ ***Baseline Staging – PET for the baseline staging of patients with metastatic melanoma OR Merkel Cell Carcinoma prior to starting immunotherapy; or for patients who are receiving immunotherapy and have not previously had a baseline PET.**
(choose one)

☐ Baseline PET **PRIOR** to patients starting immunotherapy

☐ Baseline PET for patients who are receiving immunotherapy, and have not previously had a Baseline PET

☐ ***Response Assessment – PET for response assessment of patients with metastatic melanoma OR Merkel Cell Carcinoma currently receiving immunotherapy.**

Reason for PET: ☐ Early Response Assessment (choose one): ☐ After 2 cycles ☐ After 3 cycles ☐ After 4 cycles

☐ Other (specify): after_____cycles (Merkel Cell Carcinoma only)

☐ End of Therapy Response Assessment (specify reason):
☐ Therapy Complete ☐ Adverse Event ☐ Patient Decision
☐ Radiographic Complete Response or Good Partial Response
☐ Other (specify):_____

Immunotherapy Start Date: _____ YYYY-MM-DD
Date of most recent Immunotherapy dose: _____ YYYY-MM-DD

Current Immunotherapy Regimen (select all that apply):
☐ Anti PD1 Monotherapy ☐ Anti CTLA-4 Monotherapy ☐ Anti PD1 & Anti CTLA-4 combination therapy
☐ Anti PDL1 Monotherapy
☐ Other (specify):_____

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Complete EITHER Section A or B *(not both)* **Patient Name:**_____

***Section B (continued) – PET in Immunotherapy for Metastatic Melanoma OR Merkel Cell Carcinoma**

Baseline PET scan available for comparison? ☐ No ☐ Yes (specify date): _____
YYYY-MM-DD

Residual Lesion(s) on CT?
- ☐ Not Applicable (no CT available)
- ☐ No
- ☐ Yes (specify total number & locations): Number of lesions: ☐ 1 ☐ 2 ☐ 3 ☐ ≥ 4
  Location of lesions: ☐ Lung ☐ Liver ☐ Bone ☐ Adrenal ☐ Brain
  ☐ Other (specify):_____

Does patient have clinical evidence of immune related adverse event(s)?
- ☐ No
- ☐ Yes (select all that apply): ☐ Enterocolitis ☐ Fatigue ☐ Hematological ☐ Hepatitis ☐ Hypophysitis
  ☐ Pancreatitis ☐ Rash ☐ Pneumonitis ☐ Peripheral neuropathy
  ☐ Sarcoidosis ☐ Thyroiditis ☐ Other (specify):_____

Select Management Plan – if PET were NOT available, what is your Current Management Plan

Pre-PET Treatment Plan (select all that apply):

- ☐ Start Immunotherapy (specify):
  - ☐ Anti PD1 Monotherapy
  - ☐ Anti PD1 & Anti CTLA-4 combination therapy
  - ☐ Anti CTLA-4 Monotherapy
  - ☐ Other (specify):_____
- ☐ Continue Immunotherapy
- ☐ Discontinue Immunotherapy
- ☐ Surgery
- ☐ Targeted Therapy
- ☐ Clinical Trial, (specify the protocol or SOC Name or Number):_____
- ☐ Radiation
- ☐ Chemotherapy, (specify both regimen & number of cycles): a. Regimen_____
  b. Number of Cycles:_____
- ☐ Other, please describe _____

Physician Signature:_____ **Date:** _____

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