# National Oncologic PET Registry (NOPR)

## F-18 Fluoride PET Case Report Forms

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## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0968. The time required to complete this information collection is estimated to average five (5) minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
The National Oncologic PET Registry (NOPR)

Patient Information Sheet for PET Bone Scan

You are being invited to take part in a research study conducted by the National Oncologic PET Registry (NOPR). Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to your family or friends about the study to help you decide whether or not you wish to take part. If you have any questions or if you would like more information after reading the information sheet, please go to the NOPR website, http://www.cancerpetregistry.org/, or contact the NOPR staff by telephone toll free at 800-227-5463, ext. 4859. Your doctor who ordered the PET bone scan and the staff at the PET facility where your scan will be performed will not be able to answer your questions concerning this research study. The NOPR staff will be able to assist you and answer any questions you may have.

You are being asked to participate in this research study because you are a Medicare patient and your doctor has ordered a PET or a PET/CT bone scan for you that is currently not covered (paid for) by Medicare. The PET bone scan has been ordered to evaluate for spread of cancer to bone. Having the PET scan is not the research in this study. PET bone scans are part of routine clinical care. For the research, the NOPR will study how the information obtained from the PET bone scan is used by your doctor.

WHY IS THIS STUDY BEING DONE?

The Centers for Medicare and Medicaid Services (CMS), a Federal agency that manages the Medicare program, currently does not pay for PET bone scans. However, CMS has a policy called “coverage with evidence development” (CED) to pay for PET bone scans ordered for evaluation of patients with known or suspected cancer. This means Medicare will pay for PET or PET/CT bone scans in the same way that it pays for other testing.

CMS wants to determine if they should pay for PET bone scans for evaluating spread of cancer to bone. In order to collect the information needed to make this decision, CMS will provide payment for the PET bone scans of patients who are properly registered with the National Oncologic PET Registry (NOPR). In addition, if you and your doctor agree to participate in the research, your information will be entered into the registry and will then be analyzed to determine how PET bone scans affect the way doctors plan treatment for their patients.

In order for Medicare to pay for your PET bone scan, Medicare is requiring that your doctor provide certain information about the reason for your scan and how the scan results may influence your treatment. This information, along with information about the results of your scan, will be sent by the PET facility to Medicare as a requirement for payment for your PET bone scan. In addition, the NOPR is requesting your consent to use this information for research. Specifically, the NOPR plans to study how PET scans affect the treatment plans of the doctors who order PET bone scans. Eventually, the results of this research may help to obtain coverage by Medicare and other insurers for PET bone scans.

WHAT WILL HAPPEN IF I TAKE PART IN THIS STUDY?

CMS will collect information about you from your doctor as a requirement of paying for your PET scan. Your personal information such as your name, date of birth, social security number, and your doctor’s information will be entered into NOPR database through a secure web site. All this information will be stored at the
American College of Radiology Imaging Network (ACRIN). ACRIN is a national leader in clinical research involving cancer patients. This database is secure and meets the requirements for the protection of patient confidentiality as required by the U.S. Privacy Rule (HIPAA).

As part of Medicare requirement for payment, your doctor will be asked to complete a brief questionnaire regarding his/her request for PET or PET/CT bone scan and what the doctor would do if PET or PET/CT bone scan were not available. After the PET bone scan is performed, the doctor who reads the scan will be asked to complete a brief questionnaire about the scan results and your doctor will be asked to complete a second questionnaire about how the results of the scan affected your care. These forms, along with information about the results of your scan, must be completed and submitted to the NOPR within a specified period in order for the scan to be eligible for payment. NOPR will send your information to CMS so that your PET bone scan will be paid for by Medicare, like any other covered benefit.

If you agree to participate in the research part of the NOPR, you are giving permission to use your health information for research. However, your information will only be used by the NOPR for research if you and your doctor as well as the doctor who read your scan give permission to use it for research purposes.

WHAT OTHER OPTIONS ARE THERE?

You may choose not to participate in this study. You can choose to have a PET or PET/CT bone scan without participating in the registry study. If you choose not to participate in the NOPR research study, the PET bone scan payment will not be affected.

ARE THERE POTENTIAL BENEFITS TO TAKING PART IN THE STUDY?

There is no immediate direct benefit to you for your participation in this research study. Whether or not you (or your doctor) agree to have your information used for the NOPR research study, Medicare will pay for the PET bone scan so long as your doctor provides the information Medicare requires for payment. If the research study leads to routine coverage by Medicare of PET bone scans, you may benefit in the future if you need another PET bone scan. Other patients with cancer in the future may also be helped if the research leads to routine coverage of PET bone scans by Medicare or other health insurance providers.

WHAT ARE THE RISKS OF THE STUDY?

There are no physical risks associated with this study. There is, however, the potential risk of loss of confidentiality. Every effort will be made to keep your information confidential; however, this cannot be guaranteed.

WHAT ARE THE COSTS?

There are no additional costs to you associated with participating in the NOPR research study. Medicare will pay for the PET or PET/CT bone scan if your information is submitted within a specified timeframe by your doctor. You or your Medicare supplemental (Medigap) insurance will be responsible for any co-payment costs or deductible payments, just as occurs with any other medical service covered by Medicare.

WHAT ABOUT CONFIDENTIALITY?

Your information will be kept permanently in a secure electronic database at the ACRIN and may be used for future research. CMS, the NOPR working group and project staff, and the Center for Statistical Sciences at Brown University will have access to your information. They are responsible for making a recommendation to
CMS on whether PET bone scans should be paid for by Medicare. Your records may be reviewed in order to meet federal regulations. Your name will never be made public.

**WHAT ARE MY RIGHTS?**

Your participation in the NOPR research study is voluntary. You may choose not to be in the study. If you agree to be in the study, you may withdraw from the study at any time. If you withdraw from the study, no new data about you will be collected for research purposes.

Your decision not to participate or to withdraw from the study will not involve any penalty or loss of benefits. You will continue to receive your usual medical care whether or not you decide to participate in this study. If you decide to withdraw from the study, you will need to let your doctor know in writing.

After you have had a chance to read this information sheet and have made a decision whether you want to participate, please let the staff at the PET facility know what you have decided. You are not required to sign a consent form to participate in this research, but you must let the PET facility staff know whether or not you wish to participate either before you leave the PET facility or at a later date but no more than two (2) working days after you have your PET bone scan. If you have any questions regarding the NOPR research study or the information sheet, please go to the NOPR website, [http://www.cancerpetregistry.org/](http://www.cancerpetregistry.org/) and click on “Info for Patients”, or contact NOPR at (800) 227-5463, ext. 4859 or pet_registry@phila.acr.org. If you have any questions or concerns about your rights as a research subject or about harms related to this research, you can contact Maria Oh, the American College of Radiology (ACR) IRB coordinator, at (800) 227-5463, ext. 4160. You will be given a copy of this information sheet to take home with you.

**Review and Approval by the American College of Radiology Institutional Review Board.**

Interpreting Physician Information Sheet for F-18 Fluoride PET Bone Scan

The purpose of the National Oncologic PET Registry (NOPR) is to prospectively examine how the use of PET scans impacts the management of patients with suspected or known cancer. This information will be used to develop guidelines for the effective use of PET in a variety of clinical situations and for future requests to the Centers for Medicare and Medicaid Services (CMS) to seek coverage for PET scans that are not covered outside of this registry.

Currently, CMS is providing coverage for PET bone scans in patients with known or suspected cancer under a program known as “coverage with evidence development” (CED). As a condition of payment, CMS requires that you complete a brief form that summarizes your interpretation of the PET bone scan. Information is also collected from the physician who requested the PET bone scan about his or her planned management of the patient before and after the PET bone scan. The information is entered into a secure database maintained by the NOPR and forwarded to CMS for payment purposes.

Your participation in the research component is voluntary. You may choose not to participate. If you agree to participate, you may discontinue participation at anytime. If you withdraw from the study, no new data will be collected about you for research purposes. Your decision not to participate or to withdraw from the study will not involve any penalty or loss of benefits to which you are otherwise entitled. If you agree to participate, the NOPR investigators will also use the information you provide for research purposes. The patient and the physician who requested the PET bone scan will also be asked to allow their information to be used for the same research purposes. The patient’s data and PET bone scan information in the registry will be used for research only if you, the requesting physician and the patient provide consent. However, you, the requesting physician or the patient may choose not to allow this information to be used for the research component of the NOPR. If you choose not to participate, your ability to interpret future PET bone scans will not be affected.

Whether or not you choose to participate, you will need to complete an Interpreting Physician Scan Assessment Form which is necessary for payment by CMS. If you choose to participate in the research study, the same information, as well as the actual report of the PET scan, will become part of the research data. The Interpreting Physician Scan Assessment Form asks questions related to your assessment of the scan findings and the likelihood of metastatic disease. This form should be completed at the time you interpret the PET bone scan and must be completed within 30 days after completion of the PET study.

You and the patient will not directly benefit from participating in the research component at this time. Your participation will help to identify the most effective applications of PET bone scans in oncology patients. The information will be used by CMS and other health insurance providers to decide whether to pay for PET bone scans for cancer-related indications in the future. We hope that the decision may help patients with cancer in the future.

There are no direct risks or discomfort associated with your participation. However, the completion of the Interpreting Physician Scan Assessment Form is a requirement for CMS reimbursement. Completion of the form should take approximately 5 minutes. Participation in the research component will not require additional time for you and your staff. The patient will not know your answers and of your participation in the research.

The NOPR has implemented the necessary infrastructure to ensure security of all data submitted on the Interpreting Physician Scan Assessment Form and in the actual PET scan report. However, we cannot guarantee total privacy. The information will be stored permanently at the American College of Radiology Imaging Network (ACRIN). NOPR investigators will only have access to this information for research purposes, if you consent. All data collected through the NOPR will be made available to CMS for payment purposes regardless of whether consent is given for the research component. The staff at the PET facility where the scan will be performed will not be able to answer any questions concerning this research study. If you have any questions or require any assistance, you can contact the NOPR project manager toll free at 800-227-5463, ext.4859, or pet_registry@phila.acr.org. If you have any questions or concerns about your rights as a research subject or about harms related to this research, you can contact Maria Oh, the American College of Radiology (ACR) IRB coordinator, at (800) 227-5463, ext. 4160.

If you choose to participate and allow the information collected on the Interpreting Physician Scan Assessment Form to be used for the research component of the NOPR, please check the appropriate check box to indicate your participation in the NOPR research study on the Interpreting Physician Scan Assessment Form.

Review and approval by the American College of Radiology Institutional Review Board
Referring Physician Information Sheet for F-18 Fluoride PET Bone Scan

The purpose of the National Oncologic PET Registry (NOPR) is to prospectively examine how the use of PET scans impacts the management of patients with suspected or known cancer. This information will be used to develop guidelines for the effective use of PET in a variety of clinical situations and for future requests to the Centers for Medicare and Medicaid Services (CMS) to seek coverage for PET scans that are not covered outside of this registry.

Currently, CMS is providing coverage for PET bone scans in patients with known or suspected cancer under a program known as “coverage with evidence development” (CED). As a condition of payment, CMS requires that you provide specific patient information before the PET bone scan and within 30 days after the PET bone scan. The information is entered into a secure database maintained by the NOPR and forwarded to CMS for payment purposes.

Your participation in the research component is voluntary. You may choose not to participate. If you agree to participate, you may discontinue participation at anytime. If you withdraw from the study, no new data will be collected about you for research purposes. Your decision not to participate or to withdraw from the study will not involve any penalty or loss of benefits to which you are otherwise entitled. If you agree to participate, the NOPR investigators will also use the information you provide for research purposes. Your patient and the interpreting physician will also be asked to allow their information to be used for the same research purposes. Your patient’s data and PET bone scan information in the registry will be used for research only if you, the interpreting physician, and your patient provide consent. However, you, the interpreting physician or your patient may choose not to allow this information to be used for the research component of the NOPR. If you choose not to participate, your ability to request future PET bone scans will not be affected.

Whether or not you choose to participate, you will need to complete pre- and post-PET forms which are necessary for payment by CMS. If you choose to participate in the research study, the same information will become part of the research data. The Pre-PET Form, which must be completed before or on the day of the PET bone scan, will ask you questions related to the reason for requesting the scan, the patient’s cancer type and extent, and the intended management plan if PET were not available. The Post-PET Form, which must be completed and returned to the PET facility within 30 days after the PET bone scan, will ask you questions about the impact of the PET findings on your assessment of the patient’s disease status and your current management plan for the patient.

You and your patient will not directly benefit from participating in the research component at this time. Your participation will help to identify the most effective applications of PET bone scans in oncology patients. The information will be used by CMS and other health insurance providers to decide whether to pay for PET bone scans for cancer-related indications in the future. We hope that the decision may help patients with cancer in the future.

There are no direct risks or discomfort associated with your participation. However, the completion of the pre- and post-PET forms is a requirement for CMS reimbursement. Completion of the forms should take approximately 5 minutes for each form. Participation in the research component will not require additional time for you and your staff. Your patient will not know your answers and of your participation in the research.

The NOPR has implemented the necessary infrastructure to ensure security of all data submitted on the pre- and post-PET forms. However, we cannot guarantee total privacy. The information will be stored permanently at the American College of Radiology Imaging Network (ACRIN). NOPR investigators will only have access to this information for research purposes, if you consent. All data collected through the NOPR will be made available to CMS for payment purposes regardless of whether consent is given for the research component. The staff at the PET facility where the scan will be performed will not be able to answer any questions concerning this research study. If you have any questions or require any assistance, you can contact the NOPR project manager toll free at 800-227-5463, ext.4859, or pet_registry@phila.acr.org. If you have any questions or concerns about your rights as a research subject or about harms related to this research, you can contact Maria Oh, the American College of Radiology (ACR) IRB coordinator, at (800) 227-5463, ext. 4160.

If you choose to participate and allow the information collected on the pre- and post-PET forms be used for the research component of the NOPR, please check the appropriate check box to indicate your participation in the NOPR research study on the Post-PET Form.

Review and approval by the American College of Radiology Institutional Review Board

ClinicalTrials.gov Identifier NCT00868582          Version: January 11, 2012          (Page last revised June 17, 2010)
PET Facility Registration Form
National Oncologic PET Registry

PET Facility Registration Form
National Oncologic PET Registry

• Please complete this form to finalize the NOPR registration process.
• Once this completed form is submitted, a confirmation e-mail will be sent with an invoice for the escrow account start-up funds and the $50 application fee.
• When the start-up funds are received at NOPR Headquarters an escrow account will be established for the PET Facility. $50 will be debited from this account each time the facility registers a case on the NOPR. E-mail reminders will be sent to the PET Facility Administrator when the account balance dips below a minimum level as defined by the Facility on this Registration Form.
• The PET Facility can pay the $50 registration fee and initial escrow deposit either by:
  o Mailing a check made payable to ACR-NOPR together with a copy of the e-mailed invoice to the American College of Radiology, 1818 Market Street, Suite 1600, Philadelphia, PA 19103. The facility ID# must be written on the check; or
  o Paying by credit card using the information in the e-mailed invoice and confirmation to log into the facility’s account on the NOPR Web site.
• Once the ACR receives the facility registration fee and the executed Business Associates Agreement (BAA), the PET Facility will be sent an e-mail approval notice and the facility will be eligible to participate in the National Oncologic PET Registry via the secure Web site.

Only cases that meet the criteria listed in the Coverage Decision will be eligible for registration and CMS reimbursement.

Facility ID #: ________

1. PET FACILITY INFORMATION
   Name of Imaging Center (will be supplied by the system from pre-registration information) ________________________
   Mailing Address (street 1)______________________________ (street 2)______________________________
   (city)________________________ (state)________ (zip)_______
   Telephone __________ x _______ FAX: _________________________
   Business entity responsible for payment ___________________________
   Medicare Provider Number or National Provider Identifier Number: ______________

   PHYSICAL ADDRESS OF THE PET FACILITY
   Address (street 1)______________________________ (street 2)______________________________
   (city)________________________ (state)________ (zip)_______
   Telephone __________ x __________

2. PET FACILITY ADMINISTRATOR
   Official facility contact person for the National Oncologic PET Registry (will be supplied by the system from pre-registration information)
   E-mail address (will be supplied by the system from pre-registration information)
3. **PARTICIPATING PHYSICIANS** - who will interpret PET scans? (Web form will accept as many as needed)
   
   First Name________________ Last Name____________ NPI ___________________

   First Name________________ Last Name____________ NPI ___________________

4. **STAFF** - People who are allowed to register patients and enter data into the database. A username and password will be emailed to the staff person.

   First Name________________ Last Name____________ E-mail __________________

   First Name________________ Last Name____________ E-mail __________________

5. **EQUIPMENT DESCRIPTIONS** – Provide complete information for each PET scanner. (Web Form will allow for entry of multiple scanners)

   Facility’s Scanner Identifier (facility’s name for scanner)____________________

   Manufacturer ___________________________ Model ____________________________

   ❑ Fixed    ❑ Mobile

   ❑ Hospital-Based    ❑ Not hospital-based (independent diagnostic testing facility)

6. **CALCULATION OF ESCROW ACCOUNT**

   Payment to the National Oncologic PET Registry for each case entered into the database for CMS reimbursement is required in advance. It is recommended that each facility schedule monthly payments based on the expected number of cases registered for one month. You may stop participating in the Registry at any time. Upon letter to the Program Manager any unexpended credit balance will be refunded.

   Invoice will be E-mailed to registering facility in the amount calculated below.

   Initial Facility registration fee: $50

   Number of cases to prepay @ $50 each: _______ x $50 = _______

   Total: _______

7. **FUND BALANCE REMINDER**

   PET Facilities can monitor the balance remaining in their NOPR Account via the secure Website. New cases can be registered as long as there is a positive balance remaining. It is recommended that each facility maintain a credit balance at all times commensurate with the facility’s caseload. An E-mail reminder will be sent from the Registry when your fund balance reaches the minimum threshold established by the PET Facility.

   Please notify our PET Facility when our account balance with the ACR reaches the level selected below:

   ❑ $250 – 5 cases remaining
   ❑ $500 – 10 cases remaining
   ❑ $1,000 – 20 cases remaining
   ❑ $2,000 – 40 cases remaining
8. HAS THE BUSINESS ASSOCIATE AGREEMENT (BAA) BEEN EXECUTED?

☐ Yes  ☐ No

(Please mail or fax (215-928-0153) the BAA to NOPR Headquarters. Note: patients cannot be entered on the Registry until the BAA is received at Headquarters)

9. NAME OF PERSON SUBMITTING THIS FORM

First Name: ___________________ Last Name: ___________________

Additional information on the National Oncologic PET Registry can be found on the web site, http://www.cancerPETregistry.org/ or by contacting the project manager at 215-717-0859.
PET Facility log-in information (facility ID, password): ____________________________________________

1. PATIENT INFORMATION

Date: ___/___/____ Social Security #: ___ ___ ___ — ___ ___ — ___ ___ ___

Last name: ___________________________________ First name: ___________________________________

Date of Birth: ___/___/____ Patient's Zip Code: __ __ __ __ __

Gender: [ ] Male [ ] Female Ethnicity: [ ] Hispanic [ ] Not Hispanic [ ] Unknown

Race: [ ] Asian [ ] Black or African American [ ] White or Caucasian [ ] Other [ ] Unknown

2. REFERRING PHYSICIAN INFORMATION

UPIN #: ________________________________ or NPI #: ________________________________

Last name: ___________________________________ First name: ___________________________________

Office Telephone: [___] __________________ Office Fax: [___] __________________

3. HAS THE PRE-PET FORM BEEN COMPLETED? [ ] Yes [ ] No

(if Yes is checked the PET facility will not be E-mailed a Pre-PET form to complete)

4. DATE PATIENT SCHEDULED FOR PET SCAN? ___/___/____

(Must be within 14 days of registration.)

5. NAME OF PERSON SUBMITTING THIS FORM

Last name: __________________________ First name: __________________________ Date: ___/___/____
Comment to Clinician:

- You have requested an F-18 Fluoride PET scan, a test for which the Centers for Medicare and Medicaid Services (CMS) requires pre- and post-PET information from the referring physician as a condition for reimbursement. In order for the imaging center to be reimbursed this form must be completed and returned to the PET facility before the PET scan is performed.
- You will be required to complete a follow-up form in a timely fashion after the PET scan is done. Thank you for your assistance completing the brief pre- and post-PET forms. The required follow-up questionnaire will be sent to you by the PET facility. By requesting that this patient be entered on the NOPR you agree to also complete the post-PET follow-up form and return it to the PET scan facility within 30 days of the PET scan.

PATIENT INFORMATION

Date: ______/_____/______  Social Security #: ______ ______ ______ ______ ______

Last name: ____________________________  First name: ____________________________

Date of Birth: ______/_____/______  Patient's Zip Code: ______ ______ ______

REFERRING PHYSICIAN INFORMATION

UPIN #: ____________________________  or  NPI #: ____________________________

Last name: ____________________________  First name: ____________________________

Office Telephone: [____] ______________  Office Fax: [____] ______________

1. SPECIFIC REASON FOR F-18 FLUORIDE PET STUDY

   See page 6 of this form for definitions / instructions to assist you in completing Question 1.

   a. Check the single best match for the reason for the PET (you must check only one of the following)

      ☐ Diagnosis of suspected osseous metastatic disease in a patient without a pathologically proven diagnosis of cancer
      [If this option is selected, answer only questions 1.b, 2, 3, and 6. Also, note that guidance to help you answer parts a, b, and c of question 2 is provided on page 7 of this form.]

      ☐ Initial staging of newly diagnosed cancer

      ☐ Suspected new osseous metastasis as a site of recurrence or progression

      ☐ Suspected progression of known osseous metastasis

      ☐ Monitoring Treatment Response during systemic therapy (including chemotherapy, biologic modifiers, hormonal therapy, and immunotherapy)

      ☐ Monitoring Treatment Response during radiation therapy

      ☐ Monitoring Treatment Response during combined systemic therapy and radiation therapy
b. Symptoms, signs, or other findings prompting F-18 fluoride PET bone imaging

☐ NONE
[If selected, go directly to Question 2; otherwise select all of the following that apply]

☐ Skeletal pain
☐ New focal neurologic signs or symptoms
☐ Findings on other imaging studies suggesting osseous metastatic disease
☐ Hypercalcemia
☐ Elevated or increasing tumor marker(s) (including alkaline phophatase)

☐ Evidence of new metastases in non-osseous sites
[Do not select this option if reason for study is “Diagnosis of suspected osseous metastatic disease in a patient without a pathologically proven diagnosis of cancer”.

☐ Evidence of progression of known metastatic disease in non-osseous sites
[Do not select this option if reason for study is “Diagnosis of suspected osseous metastatic disease in a patient without a pathologically proven diagnosis of cancer”.

See page 7 of this form for guidance in the completion of Question 2 when the PET bone scan is requested for “Diagnosis of suspected osseous metastatic disease in a patient without a pathologically proven diagnosis of cancer”.
2. CANCER TYPE

- Please mark the corresponding box of the pathologically proven or strongly suspected primary cancer type in section 2a and answer question 2b.
- If your patient’s cancer is not listed, check the “Other or not listed” box and enter as text the cancer type.
- For a patient with pathologically proven or strongly suspected metastatic cancer of unknown primary origin, please also mark the corresponding box of the site of metastatic disease in section 2c.

a. Cancer Type - check the one pathologically proven or strongly suspected cancer type that most closely relates to the specific reason for the PET study indicated in response to Question 1. (Check only one)

- Lung
- Female breast
- Prostate
- Metastatic cancer of unknown primary origin (also answer question 2c below)
- Other

If other, please describe cancer type: __________________________________________________________

and give the first 3 digits of the ICD-9 code. □□□.XX

b. Has this cancer diagnosis been pathologically proven? □ Yes □ No

c. Unknown primary: dominant site of pathologically proven or strongly suspected metastatic disease

- Lymph node(s)
- Lung
- Liver
- Brain
- Bone/bone marrow
- Other

If other, please indicate dominant site: _________________________________________________________

and give the first 3 digits of the ICD-9 code. □□□.XX [Acceptable responses are 196-199]

3. YOUR WORKING SUMMARY STAGE FOR THE PATIENT BEFORE THE PET SCAN IS:

(you must check only one)

- No evidence of disease / In remission
- Localized only
- Regional by direct extension or lymph node involvement or both
- Metastatic (distant) with a single suspected site
- Metastatic (distant) with multiple suspected sites
- Unknown or uncertain

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4. ADDITIONAL RESPONSES REQUIRED ONLY IF THE SPECIFIC REASON FOR THE PET STUDY IS MONITORING TREATMENT RESPONSE

a. Which of the following types of treatment is this patient now receiving?

(check one)

☐ Systemic therapy (including chemotherapy, biologic modifiers, hormonal therapy, and immunotherapy)
☐ Radiation therapy
☐ Combined systemic therapy and radiation therapy

b. What is your impression (before PET) of your patient’s response to currently ongoing therapy?

(check one)

☐ Probable complete response
☐ Possible partial response, but uncertain about degree of response
☐ Suspect no response (stable disease)
☐ Suspect progressive disease

c. If you were to continue your patient’s management without doing any other testing first (e.g., PET, CT, MRI, biopsy), what would be your treatment plan today?

(check one)

☐ Continue and complete currently ongoing therapy
☐ Modify dose or schedule of currently ongoing therapy
☐ Switch to another therapy or add another mode of therapy
☐ Stop therapy and switch to supportive care
5. MANAGEMENT PLAN

a. Has the patient had a conventional bone scan within the last month?
   - Yes
   - No

b. If the F-18 fluoride PET bone scan were not available, would you order a conventional bone scan instead?
   - Yes
   - No

c. If the F-18 fluoride PET bone scan were not available, which ONE of the following would be the next step in your current management strategy? [Note: For purposes of this question, you should assume that neither an F-18 fluoride PET bone scan nor a conventional bone scan would be available as the next step.](check only one)
   - Observation (with close follow-up)
   - Additional Imaging (CT, MRI, FDG-PET)
     [Note: Do not check this option if you would order a conventional bone scan if the F-18 fluoride PET bone scan were not available.]
     If additional imaging is selected, please indicate which specific type of imaging you would order next. *(check one)*
     - Plain radiographs
     - Body CT (spine, neck, chest, and/or abdomen/pelvis)
     - Extremity CT
     - Body MRI (neck, chest, and/or abdomen/pelvis)
     - Extremity MRI
     - FDG-PET
     - Other, specify: ______________________

- Tissue Biopsy (surgical, percutaneous, or endoscopic).
  Note: If concurrent biopsy and a surgical procedure are planned, then mark “treatment” below.

- Supportive care only (e.g., pain management, hospice care)

- Treatment for the cancer

If treatment is selected, please also answer the following (a, b and c):

a. Treatment Goal:
   *(check one)*
   - Curative
   - Palliative
b. **Treatment will be directed to:** *(check all that apply)*
   - Primary tumor and/or locoregional disease
   - Non-osseous distant metastatic disease
   - Osseous distant metastatic disease

c. **Type(s):** *(check all that apply)*
   - Surgery
   - Radiation
   - Chemotherapy (including biologic modifiers)
   - Hormonal therapy
   - Bisphosphonate therapy
   - Immunotherapy (e.g., sipuleucel T *(Provenge®)* for prostate cancer)
   - Radiopharmaceutical therapy (strontium-89, samarium-153, etc.)
   - Other
     Specify type: ________________________________________

6. **NAME OF PERSON WHO COMPLETED THE PAPER FORM**
   First Name: ___________________  Last Name: ___________________  Date: _____/_____/_____

7. **PHYSICIAN ATTESTATION OF DATA ACCURACY**
   By signing below I verify that, to the best of my knowledge, the information on this form is accurate.

   Physician Signature: ___________________________________________  Date: _____/_____/_____
   Printed Name of Physician: _______________________________________

   **Thank you for your assistance.**

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**PRA Disclosure Statement**

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ADDITONAL INSTRUCTIONS FOR COMPLETING  
PRE-PET FORM QUESTION 1

The following definitions/instructions are provided to assist you in the completion of Question 1  
(“SPECIFIC REASON FOR PET STUDY”) on the next page of this form. This information is derived  
from the 2009 Medicare National Coverage Determination for F-18 Fluoride PET.  


Indications for F-18 Fluoride PET Scans and Limitations/Requirements for Usage

Initial Treatment Strategy

F-18 Fluoride PET performed as part of an evaluation for determination of an initial treatment strategy is covered  
by CMS only with participation in this registry. F-18 fluoride PET may be used both for diagnosis of strongly  
suspected bone metastases in a patient without a pathologically proven diagnosis of cancer and as part of initial  
staging in a patient with a pathologically proven cancer.

Note: F-18 fluoride PET is covered only in clinical situations in which (1) the PET results may assist in avoiding an  
invasive diagnostic procedure, or in which (2) the PET results may assist in determining the optimal anatomical location to  
perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to doing a  
PET bone scan and therefore the scan is performed for staging rather than diagnosis.

PET is not covered as a screening test (i.e., testing patients without specific signs and symptoms of disease).

Subsequent Treatment Strategy

F-18 fluoride PET is also covered by CMS only with participation in this registry when used in subsequent treatment  
strategy to identify bone metastases in a patient with a pathologically proven cancer.

F-18 fluoride PET is covered for restaging and detection of suspected recurrences:

(1) after completion of treatment for the purpose of detecting residual disease; or
(2) for detecting suspected recurrence or metastasis; or
(3) to determine the extent of a known recurrence:
(4) if it could potentially replace one or more conventional imaging studies when it is expected that conventional  
study information is insufficient for the clinical management of the patient.
(5) Restaging applies to testing after a course of treatment is completed, and is covered subject to the conditions  
above.

Comment: As noted above, F-18 fluoride PET is not covered as a screening test (i.e., testing patients without specific  
signs and symptoms of disease) and thus is not covered for surveillance of patients treated for cancer in whom there  
is no clinical reason to suspect recurrent disease.

Treatment Monitoring

Treatment monitoring refers to use of PET to monitor tumor response to treatment during the planned course of therapy  
(i.e., when a change in therapy is anticipated).

Comment: As an example, F-18 fluoride PET performed under NOPR may be covered for monitoring after 2 or 3 of a  
planned 6 cycles of chemotherapy in a patient considered not to be responding as expected.

ClinicalTrials.gov Identifier NCT00868582          Version: January 18, 2012          (Page last revised January 18, 2012)
ADDITONAL INSTRUCTIONS FOR COMPLETING
PRE-PET FORM QUESTION 2

The following guidance is provided to assist you in answering Questions 2a, b, and c when the PET bone scan is requested for “Diagnosis of suspected osseous metastatic disease in a patient without a pathologically proven diagnosis of cancer”.

Below are several common clinical scenarios that serve as illustrations.

- A man with back pain, a markedly elevated PSA and sclerotic lesions in several vertebrae on a recent chest radiograph. Answer “Prostate to question 2a and “No” to question 2b. Do not answer question 2c.
- A woman with a long smoking history, now with a left upper lobe mass, mediastinal adenopathy, and an adrenal nodule on CT. Answer “Lung” to question 2a and “No” to question 2b. Do not answer question 2c.
- A man with multifocal bone pain and several ill-defined lytic osseous lesions on a recent chest, abdomen and pelvis CT (with no evidence of a primary tumor on the CT study). Answer “Metastatic cancer of unknown primary origin” to question 2a, “No” to question 2c, and “Bone/bone marrow” to question 2c.
- A woman with severe headache and multiple enhancing lesions on brain MRI. Answer “Metastatic cancer of unknown primary origin” to question 2a, “No” to question 2c, and “Brain” to question 2c.
PET Completion Form
National Oncologic PET Registry

- This form is completed by the PET Facility via Web-based data entry within 14 days of case registration.
- The PET scan must be completed within 14 days of case registration. If the case was registered more than 14 days prior to the PET scan the patient must be re-registered. The original case registration will be cancelled and the $50 will be refunded.

PET FACILITY ID #: ____________________________
REGISTRY CASE #: ____________________________

1. DATE SCAN COMPLETED: ___/___/___
   (must be within 14 days of registration)

2. SCAN TYPE (you must check one)
   - □ PET
   - □ PET-CT

3. REGION(S) SCANNED (you must check only one)
   - □ Limited Body Region
     (Study will be billed using CPT Codes: 78811 or 78814.)
   - □ Skull base to proximal thighs
     (Study will be billed using CPT Codes: 78812 or 78815.)
   - □ Whole-body (vertex to toes)
     (Study will be billed using CPT Codes: 78813 or 78816.)

4. SCANNER INFORMATION
   Facility’s Scanner Identifier (facility’s name for scanner) - Pull Down Menu of Facility’s Scanner Info

5. NAME OF PERSON SUBMITTING THIS FORM
   First Name: ____________________________  Last Name: ____________________________  Date: ___/___/___
This form is used to transmit the PET Report. It is completed by the PET facility via Web-based data entry within 30 days of completing the PET scan.

PET FACILITY ID #: ____________________________

REGISTRY CASE #: ____________________________

1. DATE SCAN COMPLETED: ____/____/____

2. DATE PET REPORT COMPLETED: ____/____/____

3. INTERPRETING PHYSICIAN INFORMATION

4. PET REPORT (You must enter the report as free text. No other entry method is accepted.)

   Free text
   
   Cut and paste from Microsoft Word document or other text document. You must enter the complete text of the PET report, pasting or typing all pages.

   ________________________________

5. AFTER BEING GIVEN THE NOPR PATIENT INFORMATION STATEMENT, DID THE PATIENT CONSENT TO HAVE HIS OR HER DATA USED FOR NOPR RESEARCH?
  ☐ Yes
   ☐ No

6. NAME OF PERSON SUBMITTING THIS FORM

   First Name: ____________________________  Last Name: ____________________________  Date: ____/____/____
Interpreting Physician Scan Assessment Form
National Oncologic PET Registry
F-18 Fluoride PET Scan

- This form is used to summarize the findings of the PET bone scan. It should be completed by the interpreting physician at the time the PET scan is interpreted.
- It must be submitted by the PET facility via Web-based data entry within 30 days of completing the PET scan.

PET FACILITY ID #: __________________________________________
REGISTRY CASE #: _________________________________________

1. OVERALL ASSESSMENT
   - Normal study
   - Benign skeletal abnormalities only
   - Osseous metastatic disease or primary malignant bone tumor
     - Unifocal
     - Multifocal
     - Diffuse skeletal involvement

   *If osseous metastastic disease or primary malignant bone tumor selected, indicate level of confidence*
   - Definitely present
   - Probably present
   - Equivocal

2. WAS COMPARISON MADE WITH PRIOR RADIONUCLIDE BONE IMAGING?
   - Yes
   - No

   a. If yes, indicate type of study:
      - Conventional bone scintigraphy
      - F-18 fluoride bone PET

   b. Date of prior study _____/_____/_____

ClinicalTrials.gov Identifier NCT00868582
Version: January 18, 2012
(Page last revised April 28, 2011)
c. Based on the comparison, there has been:

☐ No change; there is no evidence on prior or current study of metastatic disease
☐ Resolution of previously seen metastatic disease
☐ Improvement of previously seen metastatic disease
☐ No change in previously seen metastatic disease
☐ Worsening of previously seen metastatic disease
☐ Development of new metastatic disease on the current study (no metastatic disease was seen on the prior study)

3. I HAVE READ THE INTERPRETING PHYSICIAN INFORMATION STATEMENT AND:

☐ I DO give my consent for the inclusion of data collected for this patient in NOPR research.
☐ I DO NOT give my consent for the inclusion of data collected for this patient in NOPR research.

4. NAME OF PERSON SUBMITTING THIS FORM

First Name: ___________________  Last Name: ___________________  Date: ___/___/___

5. PHYSICIAN ATTESTATION OF DATA ACCURACY

By signing below I verify that, to the best of my knowledge, the information on this form is accurate.

Physician Signature: ___________________________________________  Date: ___/___/___

Printed Name of Physician: _______________________________________

Thank you for your assistance.

PRA Disclosure Statement

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Diagnosis of Suspected Osseous Metastasis Form
National Oncologic PET Registry
F-18 Fluoride PET Scan

PET FACILITY ID #: __________________________________________
REGISTRY CASE #: __________________________________________
PATIENT NAME: ____________________________________________

Your patient had a PET scan on: mm/dd/yyyy.
You previously indicated that the PET scan was done for diagnosis of suspected osseous metastatic disease in a patient without a pathologic diagnosis of cancer.

- After reviewing the PET report, please complete the following questions and return the form to the PET Facility.
- This form must be entered into the database within 30 days of the PET scan.

1. IN LIGHT OF THE PET FINDINGS, WHAT IS YOUR CURRENT ASSESSMENT OF THE LIKELIHOOD OF OSSEOUS METASTATIC DISEASE?
   - [ ] Definitely present
   - [ ] Probably present
   - [ ] Uncertain
   - [ ] Probably not present
   - [ ] Definitely not present

2. SINCE OBTAINING THE SCAN, HAS A TISSUE BIOPSY BEEN PERFORMED OF A SUSPICIOUS OSSEOUS SITE?
   - [ ] Yes
   - [ ] No

   If yes, indicate whether the bone biopsy results are:
   - [ ] Negative
   - [ ] Positive
   - [ ] Pending

3. HAS A PATHOLOGIC DIAGNOSIS OF CANCER BEEN CONFIRMED FROM ANY SITE?
   - [ ] Yes
   - [ ] No
4. DID THE PET SCAN ENABLE YOUR PATIENT TO AVOID ANY
   a. noninvasive diagnostic tests?  
      ☐ Yes  ☐ No
   b. any invasive procedures?  
      ☐ Yes  ☐ No

5. I HAVE READ THE REFERRING PHYSICIAN INFORMATION STATEMENT AND:
   ☐ I DO give my consent for the inclusion of data collected for this patient in NOPR research.
   ☐ I DO NOT give my consent for the inclusion of data collected for this patient in NOPR research.

6. NAME OF PERSON SUBMITTING THIS FORM
   First Name: ____________________  Last Name: ____________________  Date: ____/____/____

7. PHYSICIAN ATTESTATION OF DATA ACCURACY
   By signing below I verify that, to the best of my knowledge, the information on this form is accurate.
   Physician Signature: ___________________________________________  Date: ____/____/____
   Printed Name of Physician: ______________________________________

Thank you for your assistance.

PRA Disclosure Statement
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Your patient had a PET scan on mm/dd/yyyy. [Date will automatically be filled.]

You previously indicated that the PET scan was done for initial staging of cancer type [Cancer type will automatically be filled in from data supplied on Pre-PET form.]

- After reviewing the PET report, please complete the following questions and return the form to the PET Facility.
- This form must be entered into the database within 30 days of the PET scan.

1. COMPARED TO YOUR PRE-PET ASSESSMENT, WHAT IS YOUR IMPRESSION OF THE EXTENT OF THE PATIENT'S CANCER?
   - More extensive
   - No change
   - Less extensive

2. DID THE PET SCAN ENABLE YOUR PATIENT TO AVOID ANY
   a. noninvasive diagnostic tests?
      - Yes
      - No
   b. any invasive procedures?
      - Yes
      - No

3. YOUR POST-PET WORKING CLINICAL SUMMARY STAGING IS? (You must check only one)
   - No evidence of disease / In remission
   - Localized only
   - Regional by direct extension
   - Metastatic (distant) with a single suspected site
   - Metastatic (distant) with multiple suspected sites
   - Unknown or uncertain
4. IN LIGHT OF THE PET FINDINGS, WHICH ONE OF THE FOLLOWING ARE YOU PLANNING OR HAVE YOU ALREADY DONE AS THE NEXT STEP IN YOUR CURRENT MANAGEMENT STRATEGY? (check only one)

☐ Observation (with close follow-up)

☐ Additional Imaging

If additional imaging is selected, please indicate which specific type of imaging you would order next. (check one)

☐ Plain radiographs
☐ Body CT (spine, neck, chest, and/or abdomen/pelvis)
☐ Extremity CT
☐ Body MRI (neck, chest, and/or abdomen/pelvis)
☐ Extremity MRI
☐ FDG-PET
☐ Other, specify: ______________________

☐ Tissue Biopsy (surgical, percutaneous, or endoscopic).

[Note: If concurrent biopsy and a surgical procedure are planned, then mark “treatment” below.]

☐ Supportive care only (e.g., pain management, hospice care)

☐ Treatment for the Cancer

If treatment was selected, answer the questions below:

a. Treatment Goal: (check one)

☐ Curative
☐ Palliative

b. Treatment will be directed to: (check all that apply)

☐ Primary tumor and/or locoregional disease
☐ Non-osseous distant metastatic disease
☐ Osseous distant metastatic disease
c. Type(s): (check all that apply)

- Surgery
- Radiation
- Chemotherapy (including biologic modifiers)
- Hormonal therapy
- Bisphosphonate therapy
- Immunotherapy (e.g., sipuleucel T (Provenge®) for prostate cancer)
- Radiopharmaceutical therapy (strontium-89, samarium-153, etc.)
- Other

Specify other treatment type: ___________________________________________________

5. I HAVE READ THE REFERRING PHYSICIAN INFORMATION STATEMENT AND:

- I DO give my consent for the inclusion of data collected for this patient in NOPR research.
- I DO NOT give my consent for the inclusion of data collected for this patient in NOPR research.

6. NAME OF PERSON SUBMITTING THIS FORM

First Name: __________________ Last Name: __________________ Date: ___/___/___

7. PHYSICIAN ATTESTATION OF DATA ACCURACY

By signing below I verify that, to the best of my knowledge, the information on this form is accurate.

Physician Signature: ___________________________________________ Date: ___/___/___

Printed Name of Physician: _______________________________________

Thank you for your assistance.

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Your patient had a PET scan on mm/dd/yyyy. [Date will automatically be filled.]

You previously indicated that the PET scan was done for treatment response monitoring of cancer type [Will automatically be filled in from data supplied on Pre-PET form.] to chemo / radiation / or other therapy.

- After reviewing the PET report, please complete the following questions and return the form to the PET Facility.
- This form must be entered into the database within 30 days of the PET scan.

1. **WHAT IS YOUR CURRENT IMPRESSION (IN LIGHT OF THE PET FINDINGS) OF YOUR PATIENT’S RESPONSE TO CURRENTLY ONGOING THERAPY? (CHECK ONE)?**
   - Complete response
   - Partial response
   - No response (stable disease)
   - Progressive disease

2. **IN LIGHT OF THE PET RESULTS, HOW HAS THE PROGNOSIS FOR YOUR PATIENT CHANGED? (CHECK ONE)**
   - Better
   - No change
   - Worse

3. **PLEASE INDICATE IF AND HOW YOU WILL MODIFY YOUR THERAPEUTIC PLAN IN LIGHT OF THE PET FINDINGS.** (You must check only the one response that best characterizes your therapeutic plan)
   - Continue and complete currently ongoing therapy
   - Modify dose or schedule of currently ongoing therapy
   - Switch to another therapy or add another mode of therapy
   - Stop therapy and switch to supportive care
4. IN LIGHT OF THE PET FINDINGS, WHICH ONE OF THE FOLLOWING ARE YOU PLANNING OR HAVE YOU ALREADY DONE AS THE NEXT STEP IN YOUR CURRENT MANAGEMENT STRATEGY?

(check only one)

☐ Observation (with close follow-up)

☐ Additional Imaging
   If additional imaging is selected, please indicate which specific type of imaging you would order next. (check one)
   - ☐ Plain radiographs
   - ☐ Body CT (spine, neck, chest, and/or abdomen/pelvis)
   - ☐ Extremity CT
   - ☐ Body MRI (neck, chest, and/or abdomen/pelvis)
   - ☐ Extremity MRI
   - ☐ FDG-PET
   - ☐ Other, specify: __________________________

☐ Tissue Biopsy (surgical, percutaneous, or endoscopic).
   [Note: If concurrent biopsy and a surgical procedure are planned, then mark “treatment” below.]

☐ Supportive care only (e.g., pain management, hospice care)

☐ Treatment for the Cancer

If treatment was selected, answer the questions below:

a. Treatment Goal: (check one)
   - ☐ Curative
   - ☐ Palliative

b. Treatment will be directed to: (check all that apply)
   - ☐ Primary tumor and/or locoregional disease
   - ☐ Non-osseous distant metastatic disease
   - ☐ Osseous distant metastatic disease
Treatment Monitoring Form
National Oncologic PET Registry

Post-Scan
F-18 Fluoride PET Scan

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c. Type(s): (check all that apply)

☐ Surgery
☐ Radiation
☐ Chemotherapy (including biologic modifiers)
☐ Hormonal therapy
☐ Bisphosphonate therapy
☐ Immunotherapy (e.g., sipuleucel T (Provenge®) for prostate cancer)
☐ Radiopharmaceutical therapy (strontium-89, samarium-153, etc.)
☐ Other

Specify other treatment type: ______________________________________

---

5. DID THE PET SCAN ENABLE YOUR PATIENT TO AVOID ANY

a. noninvasive diagnostic tests?

☐ Yes
☐ No

b. any invasive procedures?

☐ Yes
☐ No

---

6. I HAVE READ THE REFERRING PHYSICIAN INFORMATION STATEMENT AND:

☐ I DO give my consent for the inclusion of data collected for this patient in NOPR research.

☐ I DO NOT give my consent for the inclusion of data collected for this patient in NOPR research.

---

7. NAME OF PERSON SUBMITTING THIS FORM

First Name: ___________________ Last Name: ___________________ Date: ___/___/____

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8. PHYSICIAN ATTESTATION OF DATA ACCURACY

By signing below I verify that, to the best of my knowledge, the information on this form is accurate.

Physician Signature: ___________________________________________ Date: ___/___/____

Printed Name of Physician: ______________________________________

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Thank you for your assistance.
PRA Disclosure Statement

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Your patient had a PET scan on *mm/dd/yyyy*. [Date will automatically be filled.]

You previously indicated that the PET scan was done for *restaging of cancer type* [Will automatically be filled in from data supplied on Pre-PET form.] to assess for:
- new osseous metastatic disease as a site of recurrence or
- progression of known osseous metastatic disease.

[Reason will automatically be filled in from data supplied on Pre-PET form.]

- After reviewing the PET report, please complete the following questions and return the form to the PET Facility.
- This form must be entered into the database within 30 days of the PET scan.

1. **COMPAARED TO YOUR PRE-PET ASSESSMENT, WHAT IS YOUR IMPRESSION OF THE EXTENT OF THE PATIENT’S CANCER?**
   - [ ] More extensive
   - [ ] No change
   - [ ] Less extensive

2. **YOUR POST-PET WORKING CLINICAL STAGING IS: (SELECT ONLY ONE)**
   - [ ] No evidence of disease / In remission
   - [ ] Low probability of local recurrence or metastases
   - [ ] Local recurrence
   - [ ] Metastatic (distant) with a single suspected site
   - [ ] Metastatic (distant) with a multiple suspected sites

3. **DID THE PET SCAN ENABLE YOUR PATIENT TO AVOID ANY**
   **a. noninvasive diagnostic tests?**
   - [ ] Yes
   - [ ] No
   **b. any invasive procedures?**
   - [ ] Yes
   - [ ] No
4. IN LIGHT OF THE PET FINDINGS, WHICH ONE OF THE FOLLOWING ARE YOU PLANNING OR HAVE YOU ALREADY DONE AS THE NEXT STEP IN YOUR CURRENT MANAGEMENT STRATEGY? (check only one)

☐ Observation (with close follow-up)

☐ Additional Imaging
  If additional imaging is selected, please indicate which specific type of imaging you would order next. (check one)
  ☐ Plain radiographs
  ☐ Body CT (spine, neck, chest, and/or abdomen/pelvis)
  ☐ Extremity CT
  ☐ Body MRI (neck, chest, and/or abdomen/pelvis)
  ☐ Extremity MRI
  ☐ FDG-PET
  ☐ Other, specify: __________________________

☐ Tissue Biopsy (surgical, percutaneous, or endoscopic).
  [Note: If concurrent biopsy and a surgical procedure are planned, then mark “treatment” below. ]

☐ Supportive care only (e.g., pain management, hospice care)

☐ Treatment for the Cancer

If treatment was selected, answer the questions below:

a. Treatment Goal: (check one)
  ☐ Curative
  ☐ Palliative

b. Treatment will be directed to: (check all that apply)
  ☐ Primary tumor and/or locoregional disease
  ☐ Non-osseous distant metastatic disease
  ☐ Osseous distant metastatic disease
c. Type(s): (check all that apply)

- Surgery
- Radiation
- Chemotherapy (including biologic modifiers)
- Hormonal therapy
- Bisphosphonate therapy
- Immunotherapy (e.g., sipuleucel T (Provenge®) for prostate cancer)
- Radiopharmaceutical therapy (strontium-89, samarium-153, etc.)
- Other
  Specify other treatment type: ____________________________________________

5. I HAVE READ THE REFERRING PHYSICIAN INFORMATION STATEMENT AND:

- I DO give my consent for the inclusion of data collected for this patient in NOPR research.
- I DO NOT give my consent for the inclusion of data collected for this patient in NOPR research.

6. NAME OF PERSON SUBMITTING THIS FORM

First Name: __________________ Last Name: __________________ Date: ___/___/___

7. PHYSICIAN ATTESTATION OF DATA ACCURACY

By signing below I verify that, to the best of my knowledge, the information on this form is accurate.

Physician Signature: ____________________________________________ Date: ___/___/___

Printed Name of Physician: __________________________________________

Thank you for your assistance.

PRA Disclosure Statement

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