

Patient Name: _____
 Address: _____
 City: _____ State: _____
 Phone #: _____

Member ID#: _____
 Apt # or Suite #: _____
 Zip Code: _____
 Birth Date: _____

Physician Name: _____
 Address: _____
 City: _____ State: _____
 Contact Person: _____ Phone #: _____ Fax #: _____

NPI #: _____
 Apt # or Suite #: _____
 Zip Code: _____

Physician Signature: _____

Deliver to Patient's Home Deliver to Physician's Office Pick-up at Local Pharmacy (Name/Phone # _____)

To be Administered From: _____ to _____ OR on: _____ Date of Request: _____

Is the patient on iron, folate and/or vitamin B12 therapy? (please check) Yes No If yes, specify: _____

LABS (Please submit a copy of the most recent labs and/or complete the following)- (lab values should be within 30 days of request)

Hb: _____ g/dL Hct: _____ % Date of labs: _____ Vit B12: _____ Folate: _____ Date of labs: _____

TSAT: _____ % (TSAT >20% and Ferritin >100 required to avoid functional iron deficiency) Ferritin: _____ ng/mL Date of labs: _____

Weight: _____ lbs or _____ kg (i.e. wt in lbs/2.2 = wt in kg)

GFR _____ ml/min/1.73m² Has the patient met the criteria for CKD (as defined by KDOQI) for \geq 3 months? (please check) Yes No

COMPLETE APPROPRIATE DIAGNOSES AND DOSING SECTION:

A. Chronic Renal Failure (CRF) Approvable Dosing for calculating INITIAL Aranesp® therapy and Re-authorization of therapy

1. Initial Therapy Calculated Dose= Weight _____ kg * 0.75mcg/kg: _____ (See table 1 below)

Table 1. Please check the corresponding prescription of Aranesp® based on the above initial calculated dose:

Prescription for calculated dose	Calculated Dose	Prescription for calculated dose	Calculated Dose
<input type="checkbox"/> 25 mcg sc every 2 weeks	1-34 mcg	<input type="checkbox"/> 150 mcg sc every 4 weeks	71-84 mcg
<input type="checkbox"/> 40 mcg sc every 2 weeks	35-44 mcg	<input type="checkbox"/> 100 mcg sc every 2 weeks	85-115 mcg
<input type="checkbox"/> 100 mcg sc every 4 weeks	45-54 mcg	<input type="checkbox"/> 200 mcg sc every 3 weeks	116-135 mcg
<input type="checkbox"/> 60 mcg sc every 2 weeks	55-70 mcg	<input type="checkbox"/> Other Rx dose: _____	Sig: _____

2. Re-authorization request: Dose: _____ Sig: _____

B. Changing a patient ALREADY ON Procrit® THERAPY to Aranesp® Dx of Type of Anemia (HIV, CA, CRF, etc.) _____

Table 2. Please check current Procrit® dose to select appropriate Aranesp® prescription:

Previous Total Procrit® dosage (U/wk)	Requested Aranesp® prescription	Previous Total Procrit® dosage (U/wk)	Requested Aranesp® prescription
<input type="checkbox"/> <4,999	12.5mg Q 2 weeks	<input type="checkbox"/> 18,000-33,999	60mcg Q week
<input type="checkbox"/> 2500 - 4,999	25mcg Q 2weeks	<input type="checkbox"/> 34,000-89,999	100mcg Q week
<input type="checkbox"/> 5,000-10,999	25mcg Q week	<input type="checkbox"/> >90,000	200mcg Q week
<input type="checkbox"/> 11,000-17,999	40mcg Q week		

To change frequency to Q 2 weeks:

- Multiply the total dose per week of Procrit® by 2 = _____ Units
- With that calculated value, use the above table to determine the every 2 week dose of Aranesp®
 Ex. Total weekly dose of Procrit® = 10,000 U. Multiply 10,000 U by 2 = 20,000 U. This falls in the range (18,000-33,999) in the table which converts to Aranesp® 60 mcg Q 2 weeks.

Dose _____ Q 2 weeks

C. Treatment Request for Anemia in Cancer Patients on Chemotherapy Check prescription accordingly.

Is the Patient currently receiving chemotherapy? {Circle one} YES NO

Please Specify Chemotherapy and Date(s) of treatment: _____

Does patient have any anemia risk factors (i.e. Co morbidities – CHF, CAD, highly myelosuppressive chemo treatment, radiation therapy, etc)?

{Circle one} YES NO If yes, please specify _____

Initial treatment prescription: 200mcg every 2 weeks, (Only approvable initial dose for treatment of anemia due to chemotherapy)

Reauthorization prescription: 200mcg every 2 weeks: No of Refills _____ Or Number of Doses Requested _____

Other prescription: Dose: _____ Sig: _____

D. Diagnosis of Anemia due to Causes Other Than Cancer and Chemotherapy Related Anemia and Chronic Renal Failure (i.e. HIV): _____

Initial or re-authorization of the requested dose: _____ Sig: _____