

Patient Name: _____ Member ID#: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____ Birth Date: _____

Physician Name: _____ NPI #: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Contact Person: _____ Phone #: _____ Fax #: _____

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: _____

