

**Physician Request Form for Aranesp®**

Fax to Pharmacy Services at 215-937-5018, or to speak to a Representative call **800-588-6767**. Form must be completed for processing.

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Phone #: \_\_\_\_\_

Member ID#: \_\_\_\_\_  
Apt # or Suite #: \_\_\_\_\_  
Zip Code: \_\_\_\_\_  
Birth Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Physician Signature: \_\_\_\_\_

NPI #: \_\_\_\_\_  
Apt # or Suite #: \_\_\_\_\_  
Zip Code: \_\_\_\_\_  
Fax #: \_\_\_\_\_

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/1.73m<sup>2</sup> 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: \_\_\_\_\_