reliance|rx℠
45 Earhart Drive, Suite 110, Amherst, NY 14221

ERYTHROPOIETIN AUTHORIZATION AND REAUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name First Name	Today's Date Date Needed
Parent/Guardian	Prescriber Hospital/Clinic
Home Phone Number ( ) Work Phone Number ( )	Phone Number ( ) Fax Number ( )
Home Address City State Zip	Address City State Zip
Ship To: ☐ Prescriber ☐ Patient's Home	Office Contact Prescriber Specialty
Language Preference ☐ English ☐ Spanish ☐ Other	
Known Allergies:	Contact Preference ☐ Phone ☐ Fax ☐ Email: _____
Weight _____ Lbs. Height ____ Ft ____ In Date of Birth ___ / ___ / ___ Sex ☐ M ☐ F	Special Instructions

INSURANCE INFORMATION

Fill out entirely or fax a copy of patient's insurance card (both sides):

Primary Insurance: _____
Name of Insured: _____
Policy #: _____
Group #: _____
Phone #: _____
Rx Drug Card #: _____

Secondary Insurance: _____
Name of Insured: _____
Policy #: _____
Group #: _____
Phone #: _____
Rx Drug Card #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____
ICD9 Code: _____
HCT: _____ Date of test: _____
Hgb: _____ Date of test: _____
Iron Stores (Ferritin Level): _____
Transferrin Saturation: _____ Date of test: _____
GFR: _____ SCr (SerumCreatinine): _____
CrCL (Creatinine Clearance): _____
Anticipated duration of myelosuppressive chemotherapy treatment: _____
_____
Is patient receiving iron supplementation? ☐Yes ☐No
If yes, please provide medication name and dosage: _____
_____
Blood Pressure: SBP _____ DBP: _____ Date of test: _____

ERYTHROPOIETIN (EPOGEN, PROCRIT)

☐New Authorization ☐Re-authorization*

Drug Name: _____

Dose: _____

Frequency: _____

Expected duration of therapy: _____