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

MITOXANTRONE AUTHORIZATION AND RE-AUTHORIZATION

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 Speciality
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: _____

Number of Relapses in Past Year: _____

Hx of Tried and Failed Therapy:

☐Avonex ☐Betaseron ☐Copaxone
☐Rebif ☐Other: _____

BSA: _____ m^2

Reason for Discontinuation: _____

_____

DRUG NAME: MITOXANTRONE

☐ New Authorization ☐ Re-authorization*

Dose: _____

Frequency: _____

Expected duration of therapy: _____

Check all that apply:

☐Pregnancy test is negative
☐Novantrone cumulative dose <140mg/m2
☐LVEF>50%
☐Neutrophil counts > 1500 cells/mm3
☐LFTs are within normal limits
☐CBC is within normal limits