reliance|rx℠
15 Earhart Drive, Suite 101, Amherst, NY 14221

ARANESP AUTHORIZATION AND RE-AUTHORIZATION

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

Last Name First Name	Today's Date
Date of Birth: Sex: Weight:	Prescriber Hospital/Clinic
Home Phone Number Work Phone Number	Phone Number Fax Number
Home Address City State Zip	Address City State Zip
Member's Insurance ID:	Office Contact:
Allergies:	Notes:

STATEMENT OF MEDICAL NECESSITY	**DRUG NAME: ARANESP**
Primary Diagnosis: _____	☐ New Authorization ☐ Re-Authorization**
ICD10 Code: _____	Dose: _____
Prior Treatments: _____	Frequency: _____
GFR: _____ On Date: _____	Expected duration of therapy: _____
Anticipated duration of myelosupressive chemotherapy treatment, if applicable: _____	
Hemoglobin: _____ Date of Test: _____	For Re-Authorization:
HCT: _____ Date of Test: _____	Hemoglobin: _____ Date of Test: _____
Blood Pressure SBP: _____ DBP: _____	HCT: _____ Date of Test: _____
Ferritin Level: _____ Date of Test: _____	Ferritin Level: _____ Date of Test: _____
Transferrin Saturation: _____ Date of Test: _____	Transferrin Saturation: _____ Date of Test: _____