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 Needed
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 Phone: Office Fax Number:
Allergies:	Office Contact:

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD10 Code: _____

Prior Treatments: _____

GFR: _____ On Date: _____

Anticipated duration of myelosupressive chemotherapy treatment, if applicable:

_____

Hemoglobin: _____ Date of Test: _____

HCT: _____ Date of Test: _____

Blood Pressure SBP: _____ DBP: _____

Ferritin Level: _____ Date of Test: _____

Transferrin Saturation: _____ Date of Test: _____

DRUG NAME: ARANESP

☐ New Authorization ☐ Re-Authorization**

Dose: _____

Frequency: _____

Expected duration of therapy: _____

For Re-Authorization:

Hemoglobin: _____ Date of Test: _____

HCT: _____ Date of Test: _____

Ferritin Level: _____ Date of Test: _____

Transferrin Saturation: _____ Date of Test: _____