

| | | |
|--|---------------------------|-------------------------------|
| APPLICANT (stamp or sticker acceptable) | PATIENT NHI: | REFERRER Reg No: |
| Reg No: | First Names: | First Names: |
| Name: | Surname: | Surname: |
| Address: | DOB: | Address: |
| | Address: | |
| | | |
| Fax Number: | | Fax Number: |

Hypoplastic and Haemolytic

Initial application — chronic renal failure

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Patient in chronic renal failure |
| and | |
| <input type="checkbox"/> | Haemoglobin is less than or equal to 100g/L |
| and | |
| <input type="checkbox"/> | Patient does not have diabetes mellitus |
| and | |
| <input type="checkbox"/> | Glomerular filtration rate is less than or equal to 30ml/min |
| or | |
| <input type="checkbox"/> | Patient has diabetes mellitus |
| and | |
| <input type="checkbox"/> | Glomerular filtration rate is less than or equal to 45ml/min |
| or | |
| <input type="checkbox"/> | Patient is on haemodialysis or peritoneal dialysis |

Initial application — myelodysplasia

Applications from any specialist. Approvals valid for 2 months.

Prerequisites(tick boxes where appropriate)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Patient has a confirmed diagnosis of myelodysplasia (MDS)* |
| and | |
| <input type="checkbox"/> | Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent |
| and | |
| <input type="checkbox"/> | Patient has very low, low or intermediate risk MDS based on the WHO classification based prognostic scoring system for myelodysplastic syndrome (WPSS) |
| and | |
| <input type="checkbox"/> | Other causes of anaemia such as B12 and folate deficiency have been excluded |
| and | |
| <input type="checkbox"/> | Patient has a serum epoetin level of < 500 IU/L |
| and | |
| <input type="checkbox"/> | The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week |

Note: Indication marked with * is an unapproved indication

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz

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Hypoplastic and Haemolytic - *continued*

Renewal — myelodysplasia

Current approval Number (if known):.....

Applications from any specialist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

| | |
|--------------------------|---|
| <input type="checkbox"/> | The patient's transfusion requirement continues to be reduced with erythropoietin treatment |
| and | |
| <input type="checkbox"/> | Transformation to acute myeloid leukaemia has not occurred |
| and | |
| <input type="checkbox"/> | The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week |

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Signed: Date:

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