

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER** Reg No: .....

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

.....      Address: .....      .....

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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)

Patient in chronic renal failure  
**and**  
 Haemoglobin is less than or equal to 100g/L  
**and**

Patient does not have diabetes mellitus  
**and**  
 Glomerular filtration rate is less than or equal to 30ml/min

**or**

Patient has diabetes mellitus  
**and**  
 Glomerular filtration rate is less than or equal to 45ml/min

**or**  
 Patient is on haemodialysis or peritoneal dialysis

**Initial application — myelodysplasia**  
Applications from any specialist. Approvals valid for 2 months.  
**Prerequisites**(tick boxes where appropriate)

Patient has a confirmed diagnosis of myelodysplasia (MDS)\*  
**and**  
 Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent  
**and**  
 Patient has very low, low or intermediate risk MDS based on the WHO classification based prognostic scoring system for myelodysplastic syndrome (WPSS)  
**and**  
 Other causes of anaemia such as B12 and folate deficiency have been excluded  
**and**  
 Patient has a serum epoetin level of < 500 IU/L  
**and**  
 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](mailto: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
<b>and</b>	
<input type="checkbox"/>	Transformation to acute myeloid leukaemia has not occurred
<b>and</b>	
<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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