

**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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