ERYTHROPOIETIN PROGRAM APPROVAL FORM

Fax requests to (902) 368-4905, email to drugprograms@gov.pe.ca

OR mail requests to PEI Pharmacare, P.O. Box 2000, Charlottetown, PE, C1A 7N8

Patient Name:									**Date of Birth:**	
P.E.I. Health Card Number:									**Sex: Male** ☐	**Female** ☐
Mailing Address:			**City or Town:**						**Postal Code:**	
Home Phone Number:			**Work Phone Number:**						**Contact Name & Number:**	

Referring Source: Nephrologist Office ☐ **CRIC** ☐ **HDU** ☐ **Transplant Clinic** ☐ **Other** ☐

Referral Phone Number: **Referral Fax Number:**

For the Treatment of Severe Anemia related to Chronic Renal Failure in Patient with:

☐ **1. Normocytic normochromie anemia, requiring transfusions in patients who have evidence of iron overload (Ferritin >1000 ng/ml).**

☐ **2. Anemia requiring blood transfusions in patients having symptomatic angina and/or heart failure.**

☐ **3. Anemia requiring transfusions in patients with difficulties in blood grouping and febrile reactions due to antibodies.**

☐ **4. Anemia requiring transfusions in patients who have high levels of panel reactive anti HLA antibodies.**

☐ **5. Patients with severe normocytic normochromic anemia (Hb <100g/l) whose only symptoms is fatigue and have never received transfusions**

Serum Ferritin Level: **Hb Level:**

Drug Requested: **Eprex™ (Epoetin Alpha)** G **Aranesp™ (Darbepoetin Alfa)** G

Specify dosage, route, and frequency:

Nephrologist's Name: **Nephrologist's Signature:** **Date:**

Prescription Given to Patient? Yes ☐ **No** ☐ | **Administration Will Be By: Self** ☐ **Home Care** ☐ **Other** ☐

Name of PEI Family Physician:

Fax or mail completed form to:

Erythropoietin Program
PEI Pharmacare
16 Fitzroy Street, Box 2000
Charlottetown, PE C1A 7N8
Fax: 902-368-4905

Prescription to be filled at: **QEH** ☐ **PCH** ☐ **KCMH** ☐ **SH** ☐ **CHO** ☐ **WH** ☐

Notification: Patient ☐ **PEI Physician** ☐ **Referring Source** ☐ **Hospital Pharmacy** ☐ **Dialysis Unit** ☐ **Home Care** ☐