REQUEST FORM FOR EPREX* (EPOETIN ALFA) FOR THE TREATMENT OF ANEMIA DUE TO MALIGNANT CANCER UNDERGOING MYELOSUPPRESSIVE CHEMOTHERAPY

For patients with anemia due to treatment with myelosuppressive therapy for malignant cancer with Eprex therapy with a Hemoglobin count < 100 g/L

Patient name:	DOB: Weight:	Health card #: (ODB Eligibility # if different)
Physician Name: CPSO Number:	Address:	Tel #: Fax #:
Pharmacy Name:		Tel#: Fax#:

Requested dose:

- ☐ 40,000 IU sc once a week for 12 weeks (dose to increase to 60,000 IU sc if no response after 4 weeks) Eprex 40,000 IU/mL* PFS and/or 20,000 IU/mL* vial DIN # 02240722 and/ or 02206072

- ☐ 150 IU/kg sc three times a week for 12 weeks (dose to increase to 300 IU/kg sc if no response after 4 weeks) Eprex 10,000 IU/mL* PFS and/or 20,000 IU/mL* vial DIN # 02231587 and/ or 02206072

* Both are requested to permit responsive dose adjustments

Start date:	
End date:	

Diagnosis:

Date of Diagnosis:	
Tumour Type:	
Chemotherapy Protocol:	
Date of Chemotherapy initiation:	
# courses given / remaining:	

Hemoglobin level:

	Date	Results
Baseline Hemoglobin at Diagnosis:		
Current Hemoglobin:		

Transfusion History:

Physician's Signature:________________ Date:________________

Please send the completed form to the Section 8 Unit, Drug Programs Branch, 3rd Floor, 5700 Yonge Street, North York, ON, M2M 4K6, **OR** the form can be faxed to the Branch at (416) 327-7526.

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