

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

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

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

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

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Fax Number: .....      Fax Number: .....

**Cetuximab**

**Initial application**

Applications only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck
- and**
- Patient is contraindicated to, or is intolerant of, cisplatin
- and**
- Patient has good performance status
- and**
- To be administered in combination with radiation therapy

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

Signed: ..... Date: .....

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)