Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1894
October 2021

APPLICANT (stamp or sticker acceptable)	**PATIENT** NHI:	**REFERRER** Reg No: .....
Reg No:	First Names:	First Names: .....
Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

Palbociclib (Ibrance)

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 unresectable locally advanced or metastatic breast cancer
- **and** ☐ There is documentation confirming disease is hormone-receptor positive and HER2-negative
- **and** ☐ Patient has an ECOG performance score of 0-2
- **and**
  - **second or subsequent line setting**
    - ☐ Disease has relapsed or progressed during prior endocrine therapy
  - **or**
    - **first line setting**
      - ☐ Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal state
      - **and**
        - ☐ Patient has not received prior systemic treatment for metastatic disease
        - **or**
          - ☐ Patient commenced treatment with palbociclib in combination with an endocrine agent prior to 1 April 2020
          - **and** ☐ Patient has not received prior systemic endocrine treatment for metastatic disease
          - **and** ☐ There is no evidence of progressive disease
- **and** ☐ Treatment must be used in combination with an endocrine partner

Renewal

Current approval Number (if known):.....

Applications only from a medical oncologist or medical practitioner on the recommendation of a Medical oncologist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Treatment must be used in combination with an endocrine partner
- **and** ☐ No evidence of progressive disease
- **and** ☐ The treatment remains appropriate and the patient is benefitting from treatment

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