APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2047
November 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: .....

Lenalidomide

Initial application — Relapsed/refractory disease
Applications only from a haematologist or any relevant practitioner on the recommendation of a haematologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has relapsed or refractory multiple myeloma with progressive disease

and

- ☐ Patient has not previously been treated with lenalidomide

and

- ☐ Lenalidomide to be used as third line* treatment for multiple myeloma

or

- ☐ Lenalidomide to be used as second line treatment for multiple myeloma

and

- ☐ The patient has experienced severe (grade 3 or higher), dose limiting, peripheral neuropathy with either bortezomib or thalidomide that precludes further treatment with either of these treatments

and

- ☐ Lenalidomide to be administered at a maximum dose of 25 mg/day in combination with dexamethasone

Initial application — Maintenance following first-line autologous stem cell transplant (SCT)
Applications only from a haematologist or any relevant practitioner on the recommendation of a haematologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has newly diagnosed symptomatic multiple myeloma and has undergone first-line treatment that included an autologous stem cell transplantation

and

- ☐ Patient has at least a stable disease response in the first 100 days after transplantation

and

- ☐ Lenalidomide maintenance is to be commenced within 6 months of transplantation

and

- ☐ Lenalidomide to be administered at a maximum dose of 15 mg/day

Renewal — Relapsed/refractory disease

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

Applications only from a haematologist or any relevant practitioner on the recommendation of a haematologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ No evidence of disease progression

and

- ☐ The treatment remains appropriate and 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

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Lenalidomide *- continued*

Renewal — Maintenance following first line autologous SCT

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

Applications only from a haematologist or any relevant practitioner on the recommendation of a haematologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

☐ No evidence of disease progression

and

☐ The treatment remains appropriate and patient is benefitting from treatment

Note: Indication marked with * is an unapproved indication. A line of treatment is considered to comprise either: a) a known therapeutic chemotherapy regimen and supportive treatments or b) a transplant induction chemotherapy regimen, stem cell transplantation and supportive treatments. Prescriptions must be written by a registered prescriber in the lenalidomide risk management programme operated by the supplier.

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