

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:

Dasatinib

Initial application

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	The patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis or accelerated phase
and	<input type="checkbox"/>
	Maximum dose of 140 mg/day
or	
<input type="checkbox"/>	The patient has a diagnosis of Philadelphia chromosome-positive acute lymphoid leukaemia (Ph+ ALL)
and	<input type="checkbox"/>
	Maximum dose of 140 mg/day
or	
<input type="checkbox"/>	The patient has a diagnosis of CML in chronic phase
and	<input type="checkbox"/>
	Maximum dose of 100 mg/day
and	
<input type="checkbox"/>	Patient has documented treatment failure* with imatinib
or	
<input type="checkbox"/>	Patient has experienced treatment-limiting toxicity with imatinib precluding further treatment with imatinib
or	
<input type="checkbox"/>	Patient has high-risk chronic-phase CML defined by the Sokal or EURO scoring system
or	
<input type="checkbox"/>	Patients is enrolled in the KISS study** and requires dasatinib treatment according to the study protocol

Renewal

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

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Lack of treatment failure while on dasatinib*
and	<input type="checkbox"/>
	Dasatinib treatment remains appropriate and the patient is benefiting from treatment
and	<input type="checkbox"/>
	Maximum dasatinib dose of 140 mg/day for accelerated or blast phase CML and Ph+ ALL, and 100 mg/day for chronic phase CML

Note: *treatment failure for CML as defined by Leukaemia Net Guidelines. **Kinase-Inhibition Study with Sprycel Start-up <https://www.cancertrialsnz.ac.nz/kiss/>

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