

**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: .....

**Nivolumab**

**Initial application**

Applications only from a medical oncologist. Approvals valid for 4 months.

**Prerequisites**(tick boxes where appropriate)

Patient has metastatic or unresectable melanoma (excluding uveal) stage III or IV

and  Baseline measurement of overall tumour burden is documented clinically and radiologically

and  The patient has ECOG performance score of 0-2

and

Patient has not received funded pembrolizumab

or

Patient has received an initial Special Authority approval for pembrolizumab and has discontinued pembrolizumab within 12 weeks of starting treatment due to intolerance

and  The cancer did not progress while the patient was on pembrolizumab

and  Documentation confirming that the patient has been informed and acknowledges that funded treatment with nivolumab will not be continued if their disease progresses

**Renewal — less than 24 months on treatment**

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

Applications only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months.

**Prerequisites**(tick boxes where appropriate)

Patient's disease has had a complete response to treatment

or  Patient's disease has had a partial response to treatment

or  Patient has stable disease

and  Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period

and  The treatment remains clinically appropriate and the patient is benefitting from the treatment

or

Patient has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression

and  Patient has signs of disease progression

and  Disease has not progressed during previous treatment with nivolumab

**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)

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

**Nivolumab** - *continued*

**Renewal — more than 24 months on treatment**

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

Applications only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient has been on treatment for more than 24 months
<b>and</b>	
<input type="checkbox"/>	Patient's disease has had a complete response to treatment
<b>or</b>	
<input type="checkbox"/>	Patient's disease has had a partial response to treatment
<b>or</b>	
<input type="checkbox"/>	Patient has stable disease
<b>and</b>	
<input type="checkbox"/>	Response to treatment in target lesions has been determined by comparable radiologic or clinical assessment following the most recent treatment period
<b>and</b>	
<input type="checkbox"/>	The treatment remains clinically appropriate and the patient is benefitting from the treatment
<b>or</b>	
<input type="checkbox"/>	Patient has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression
<b>and</b>	
<input type="checkbox"/>	Patient has signs of disease progression
<b>and</b>	
<input type="checkbox"/>	Disease has not progressed during previous treatment with nivolumab

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)