

**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: .....

**Niraparib**

**Initial application**

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- Patient has advanced high-grade serous\* epithelial ovarian, fallopian tube, or primary peritoneal cancer
- and  Patient has received at least one line\*\* of treatment with platinum-based chemotherapy
- and  Patient has experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy
- and  Patient has not previously received funded treatment with a PARP inhibitor
- and
  - Treatment will be commenced within 12 weeks of the patient’s last dose of the preceding platinum-based regimen
  - or  Patient commenced treatment with niraparib prior to 1 May 2024
- and  Treatment to be administered as maintenance treatment
- and  Treatment not to be administered in combination with other chemotherapy

**Renewal**

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

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- No evidence of progressive disease
- and  Treatment to be administered as maintenance treatment
- and  Treatment not to be administered in combination with other chemotherapy
- and
  - Treatment with niraparib to cease after a total duration of 36 months from commencement
  - or  Treatment with niraparib is being used in the second-line or later maintenance setting

Note: \* "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component.

\*\*A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments

**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)