

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:

Cetuximab

Initial application — head and neck cancer, locally advanced
Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck
and
 Cisplatin is contraindicated or has resulted in intolerable side effects
and
 Patient has an ECOG performance score of 0-2
and
 To be administered in combination with radiation therapy

Initial application — colorectal cancer, metastatic
Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

Patient has metastatic colorectal cancer located on the left side of the colon (see Note)
and
 There is documentation confirming disease is RAS and BRAF wild-type
and
 Patient has an ECOG performance score of 0-2
and
 Patient has not received prior funded treatment with cetuximab
and
 Cetuximab is to be used in combination with chemotherapy
or
 Chemotherapy is determined to not be in the best interest of the patient based on clinician assessment

Renewal — colorectal cancer, metastatic
Current approval Number (if known):.....
Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.
Prerequisites(tick box where appropriate)

There is no evidence of disease progression
Note: Left-sided colorectal cancer comprises of the distal one-third of the transverse colon, the splenic flexure, the descending colon, the sigmoid colon, or the rectum.

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