

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:

Ibrutinib

Initial application — previously untreated chronic lymphocytic leukaemia in combination with venetoclax

Applications from any relevant practitioner. Approvals valid for 15 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Individual is currently on treatment with ibrutinib and/or venetoclax and met all of the following criteria prior to commencing treatment
or	
<input type="checkbox"/>	Individual has previously untreated CLL
and	
<input type="checkbox"/>	Ibrutinib is to be administered at a maximum dose of 420 mg daily for 3 (28 day) cycles as monotherapy, followed by a maximum of 12 (28 day) cycles in combination with venetoclax

Initial application — chronic lymphocytic leukaemia (CLL)

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Individual has chronic lymphocytic leukaemia (CLL) requiring therapy
and	
<input type="checkbox"/>	Ibrutinib is to be used as monotherapy
and	
<input type="checkbox"/>	Individual has experienced intolerable side effects, or their disease has relapsed or is refractory following at least one prior line of therapy
and	
<input type="checkbox"/>	Individual has not received ibrutinib monotherapy previously

Renewal — chronic lymphocytic leukaemia (CLL)

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites(tick box where appropriate)

<input type="checkbox"/>	There is no evidence of disease progression
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Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)*. Indications marked with * are Unapproved indications.

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz