Enquiries to Ministry of Health 0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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) The patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis or accelerated phase and Maximum dose of 140 mg/day or The patient has a diagnosis of Philadelphia chromosome-positive acute lymphoid leukaemia (Ph+ ALL) and Maximum dose of 140 mg/day or The patient has a diagnosis of CML in chronic phase and Maximum dose of 100 mg/day and Patient has documented treatment failure* with imatinib or Patient has experienced treatment-limiting toxicity with imatinib precluding further treatment with imatinib or Patient has high-risk chronic-phase CML defined by the Sokal or EURO scoring system or Patients is enrolled in the KISS study** and requires dasatinib treatment according to the study protocol				
Renewal Current approval Number (if known):				
and Dasatinib treatment remains appropriate and the patient is benefiting from treatment and				
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.cancertrialspry.ac.prz/kis				

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