

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:

Lenalidomide

Initial application — Relapsed/refractory disease

Applications only from a haematologist or any relevant practitioner on the recommendation of a haematologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

Patient has relapsed or refractory multiple myeloma with progressive disease
and Patient has not previously been treated with lenalidomide
and

Lenalidomide to be used as third line* treatment for multiple myeloma
or

Lenalidomide to be used as second line treatment for multiple myeloma
and The patient has experienced severe (grade 3 or higher), dose limiting, peripheral neuropathy with either bortezomib or thalidomide that precludes further treatment with either of these treatments

and Lenalidomide to be administered at a maximum dose of 25 mg/day in combination with dexamethasone

Initial application — Maintenance following first-line autologous stem cell transplant (SCT)

Applications only from a haematologist or any relevant practitioner on the recommendation of a haematologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

Patient has newly diagnosed symptomatic multiple myeloma and has undergone first-line treatment that included an autologous stem cell transplantation
and Patient has at least a stable disease response in the first 100 days after transplantation
and Lenalidomide maintenance is to be commenced within 6 months of transplantation
and Lenalidomide to be administered at a maximum dose of 15 mg/day

Renewal — Relapsed/refractory disease

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

Applications only from a haematologist or any relevant practitioner on the recommendation of a haematologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

No evidence of disease progression
and The treatment remains appropriate and patient is benefitting from treatment

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

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Lenalidomide - *continued*

Renewal — Maintenance following first line autologous SCT

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

Applications only from a haematologist or any relevant practitioner on the recommendation of a haematologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	No evidence of disease progression
and	
<input type="checkbox"/>	The treatment remains appropriate and patient is benefitting from treatment

Note: Indication marked with * is an unapproved indication. A line of treatment is considered to comprise either: a) a known therapeutic chemotherapy regimen and supportive treatments or b) a transplant induction chemotherapy regimen, stem cell transplantation and supportive treatments. Prescriptions must be written by a registered prescriber in the lenalidomide risk management programme operated by the supplier.

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

Signed: Date:

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