

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:

Azacitidine

Initial application

Applications only from a haematologist or medical practitioner on the recommendation of a haematologist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> The patient has International Prognostic Scoring System (IPSS) intermediate-2 or high risk myelodysplastic syndrome or <input type="checkbox"/> The patient has chronic myelomonocytic leukaemia (10%-29% marrow blasts without myeloproliferative disorder) or <input type="checkbox"/> The patient has acute myeloid leukaemia with 20-30% blasts and multi-lineage dysplasia, according to World Health Organisation Classification (WHO)
and
<input type="checkbox"/> The patient has performance status (WHO/ECOG) grade 0-2
and
<input type="checkbox"/> The patient has an estimated life expectancy of at least 3 months

Renewal

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

Applications only from a haematologist or medical practitioner on the recommendation of a haematologist. Approvals valid for 12 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

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