

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:

Atezolizumab

Initial application — non-small cell lung cancer second line monotherapy
Applications only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

Patient has locally advanced or metastatic non-small cell lung cancer
and

Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC
and

For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain
and

Patient has an ECOG 0-2
and

Patient has documented disease progression following treatment with at least two cycles of platinum-based chemotherapy
and

Atezolizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a maximum of 16 weeks
and

Baseline measurement of overall tumour burden is documented clinically and radiologically

Renewal — non-small cell lung cancer second line monotherapy
Current approval Number (if known):.....
Applications only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

Patient's disease has had a complete response to treatment
or

Patient's disease has had a partial response to treatment
or

Patient has stable disease

and

Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period
and

No evidence of disease progression
and

The treatment remains clinically appropriate and patient is benefitting from treatment
and

Atezolizumab to be used at a maximum dose of 1200 mg every three weeks (or equivalent)
and

Treatment with atezolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)

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