

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
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Fax Number: .....	.....	Fax Number: .....

**Pegylated Interferon alfa-2A**

**Initial application — chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant**

Applications from any specialist. Approvals valid for 18 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection <b>or</b> <input type="checkbox"/> Patient has chronic hepatitis C and is co-infected with HIV <b>or</b> <input type="checkbox"/> Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant <b>and</b> <input type="checkbox"/> Maximum of 48 weeks therapy
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**Renewal — Chronic hepatitis C - genotype 1 infection**

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

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> Patient has chronic hepatitis C, genotype 1 <b>and</b> <input type="checkbox"/> Patient has had previous treatment with pegylated interferon and ribavirin <b>and</b> <input type="checkbox"/> Patient has responder relapsed <b>or</b> <input type="checkbox"/> Patient was a partial responder <b>and</b> <input type="checkbox"/> Patient is to be treated in combination with boceprevir <b>and</b> <input type="checkbox"/> Maximum of 48 weeks therapy
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**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](mailto:customerservice@health.govt.nz)

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**Pegylated Interferon alfa-2A** - *continued*

**Initial application — Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior**

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient has chronic hepatitis C, genotype 1
<b>and</b>	
<input type="checkbox"/>	Patient has had previous treatment with pegylated interferon and ribavirin
<b>and</b>	
<input type="checkbox"/>	Patient has responder relapsed
<b>or</b>	
<input type="checkbox"/>	Patient was a partial responder
<b>or</b>	
<input type="checkbox"/>	Patient received interferon treatment prior to 2004
<b>and</b>	
<input type="checkbox"/>	Patient is to be treated in combination with boceprevir
<b>and</b>	
<input type="checkbox"/>	Maximum of 48 weeks therapy

**Initial application — chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV**

Applications from any specialist. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient has chronic hepatitis C, genotype 2 or 3 infection
<b>and</b>	
<input type="checkbox"/>	Maximum of 6 months therapy

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**Pegylated Interferon alfa-2A** - *continued*

**Initial application — Hepatitis B**

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.

**Prerequisites**(tick boxes where appropriate)

Patient has confirmed Hepatitis B infection (HBsAg positive for more than 6 months)

**and**  Patient is Hepatitis B treatment-naive

**and**  ALT > 2 times Upper Limit of Normal

**and**  HBV DNA < 10 log<sub>10</sub> IU/ml

**and**

HBeAg positive

**or**

Serum HBV DNA greater than or equal to 2,000 units/ml and significant fibrosis (Metavir Stage F2 or greater or moderate fibrosis)

**and**  Compensated liver disease

**and**  No continuing alcohol abuse or intravenous drug use

**and**  Not co-infected with HCV, HIV or HDV

**and**  Neither ALT nor AST > 10 times upper limit of normal

**and**  No history of hypersensitivity or contraindications to pegylated interferon

**and**  Maximum of 48 weeks therapy

**Initial application — myeloproliferative disorder or cutaneous T cell lymphoma**

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

**Prerequisites**(tick boxes where appropriate)

Patient has a cutaneous T cell lymphoma\*

**or**

Patient has a myeloproliferative disorder\*

**and**  Patient is intolerant of hydroxyurea

**and**  Treatment with anagrelide and busulfan is not clinically appropriate

**or**

Patient has a myeloproliferative disorder

**and**  Patient is pregnant, planning pregnancy or lactating

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**Pegylated Interferon alfa-2A** - *continued*

**Renewal — myeloproliferative disorder or cutaneous T cell lymphoma**

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

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	No evidence of disease progression
<b>and</b>	
<input type="checkbox"/>	The treatment remains appropriate and patient is benefitting from treatment
<b>and</b>	
<input type="checkbox"/>	Patient has a cutaneous T cell lymphoma*
<b>or</b>	
<input type="checkbox"/>	Patient has a myeloproliferative disorder*
<b>and</b>	
<input type="checkbox"/>	Remains intolerant of hydroxyurea and treatment with anagrelide and busulfan remains clinically inappropriate
<b>or</b>	
<input type="checkbox"/>	Patient is pregnant, planning pregnancy or lactating

Note: Indications marked with \* are unapproved indications.

**Initial application — post-allogenic bone marrow transplant**

Applications from any relevant practitioner. Approvals valid for 3 months.

**Prerequisites**(tick box where appropriate)

Patient has received an allogenic bone marrow transplant\* and has evidence of disease relapse

**Renewal — post-allogenic bone marrow transplant**

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

Applications from any relevant practitioner. Approvals valid for 3 months.

**Prerequisites**(tick box where appropriate)

Patient is responding and ongoing treatment remains appropriate

Note: Indications marked with \* are unapproved indications.

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