

**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: .....

**Nilotinib**

**Initial application**

Applications only from a haematologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

Patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis, high risk chronic phase, or in chronic phase

**and**

Patient has documented CML treatment failure\* with a tyrosine kinase inhibitor (TKI)

**or**

Patient has experienced treatment limiting toxicity with a tyrosine kinase inhibitor (TKI) precluding further treatment

**and**

Maximum nilotinib dose of 800 mg/day

**and**

Subsidised for use as monotherapy only

Note: \*treatment failure as defined by Leukaemia Net Guidelines.

**Renewal**

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

Applications only from a haematologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

Lack of treatment failure while on nilotinib as defined by Leukaemia Net Guidelines

**and**

Nilotinib treatment remains appropriate and the patient is benefiting from treatment

**and**

Maximum nilotinib dose of 800 mg/day

**and**

Subsidised for use as monotherapy only

**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)