

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:

Bortezomib

<p>Initial application — plasma cell dyscrasia Applications from any relevant practitioner. Approvals valid without further renewal unless notified.</p> <p>Prerequisites(tick box where appropriate)</p> <p><input type="checkbox"/> The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment</p>
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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