Enquiries to Ministry of Health 0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Ibrutinib		
Initial application — chronic lymphocytic leukaemia (CLL) Applications from any relevant practitioner. Approvals valid for 6 months. Prerequisites(tick boxes where appropriate) Patient has chronic lymphocytic leukaemia (CLL) requiring therapy and Patient has not previously received funded ibrutinib and Ibrutinib is to be used as monotherapy and Patient has experienced intolerable side effects with venetoclax monotherapy or Patient has received at least one prior immunochemotherapy for CLL and Patient's CLL has relapsed within 36 months of previous treatment and Patient's CLL is refractory to or has relapsed within 36 months of a venetoclax regimen Renewal — chronic lymphocytic leukaemia (CLL)		
Current approval Number (if known):		
Applications from any relevant practitioner. Approvals valid for 12 months. Prerequisites(tick boxes where appropriate)		
No evidence of clinical disease progression and		
The treatment remains appropriate and the patient is benefitting from treatment		

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)*. Indications marked with * are Unapproved indications.

I confirm the above details are correct and that in signing this form I understand I may be audited.