

<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: .....
.....	Address: .....	.....
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Fax Number: .....	.....	Fax Number: .....

**Bevacizumab**

**Initial application — unresectable hepatocellular carcinoma**

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> Patient is currently on treatment with bevacizumab, and met all remaining criteria prior to commencing treatment
or
<input type="checkbox"/> Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma
and
<input type="checkbox"/> Patient has preserved liver function (Child-Pugh A)
and
<input type="checkbox"/> Transarterial chemoembolisation (TACE) is unsuitable
and
<input type="checkbox"/> Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma
or
<input type="checkbox"/> Patient received funded lenvatinib before 1 March 2025
or
<input type="checkbox"/> Patient has experienced treatment-limiting toxicity from treatment with lenvatinib
and
<input type="checkbox"/> No disease progression since initiation of lenvatinib
and
<input type="checkbox"/> Patient has an ECOG performance status of 0-2
and
<input type="checkbox"/> To be given in combination with atezolizumab

**Renewal — unresectable hepatocellular carcinoma**

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

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick box where appropriate)

There is no evidence of disease progression

**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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**Bevacizumab - continued**

**Initial application — advanced or metastatic ovarian cancer**

Applications from any relevant practitioner. Approvals valid for 4 months.

**Prerequisites**(tick boxes where appropriate)

The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer

or

The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary peritoneal cancer

and

Debulking surgery is inappropriate

or

The cancer is sub-optimally debulked (maximum diameter of any gross residual disease greater than 1cm)

and

Bevacizumab to be administered at a maximum dose of 15 mg/kg every three weeks

and

18 weeks concurrent treatment with chemotherapy is planned

**Renewal — advanced or metastatic ovarian cancer**

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

Applications from any relevant practitioner. Approvals valid for 4 months.

**Prerequisites**(tick box where appropriate)

There is no evidence of disease progression

**Initial application — Recurrent Respiratory Papillomatosis**

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

**Prerequisites**(tick boxes where appropriate)

Maximum of 6 doses

and

The patient has recurrent respiratory papillomatosis

and

The treatment is for intra-lesional administration

**Renewal — Recurrent Respiratory Papillomatosis**

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

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

**Prerequisites**(tick boxes where appropriate)

Maximum of 6 doses

and

The treatment is for intra-lesional administration

and

There has been a reduction in surgical treatments or disease regrowth as a result of treatment

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**Bevacizumab** - *continued*

**Initial application — Ocular Conditions**  
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> Ocular neovascularisation
<b>or</b>
<input type="checkbox"/> Exudative ocular angiopathy

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

Signed: ..... Date: .....  
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