

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:

Sirolimus (Rapamune)

Initial application

Applications from any medical practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick box where appropriate)

☐ The drug is to be used for rescue therapy for an organ transplant recipient

Note: Rescue therapy defined as unresponsive to calcineurin inhibitor treatment as defined by refractory rejection; or intolerant to calcineurin inhibitor treatment due to any of the following:

- GFR < 30 ml/min; or
- Rapidly progressive transplant vasculopathy; or
- Rapidly progressive obstructive bronchiolitis; or
- HUS or TTP; or
- Leukoencephalopathy; or
- Significant malignant disease

Initial application — severe non-malignant lymphovascular malformations*

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

Prerequisites(tick boxes where appropriate)

- ☐ Patient has severe non-malignant lymphovascular malformation*
- and
- or

☐ Malformations are not adequately controlled by sclerotherapy and surgery

or

☐ Malformations are widespread/extensive and sclerotherapy and surgery are not considered clinically appropriate

or

☐ Sirolimus is to be used to reduce malformation prior to consideration of surgery
- and
- ☐ Patient is being treated by a specialist lymphovascular malformation multi-disciplinary team
- and
- ☐ Patient has measurable disease as defined by RECIST version 1.1 (see Note)

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

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:

Sirolimus (Rapamune) - continued

Renewal — severe non-malignant lymphovascular malformations*

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

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

Prerequisites(tick boxes where appropriate)

- ☐ Patient's disease has had either a complete response or a partial response to treatment, or patient has stable disease according to RECIST version 1.1 (see Note)
- or
- ☐ Patient's disease has stabilised or responded clinically and disease response to treatment has been clearly documents in patient notes

and

- ☐ No evidence of progressive disease

and

- ☐ The treatment remains clinically appropriate and the patient is benefitting from the treatment

Note: Baseline assessment and disease responses to be assessed according to the Response Evaluation Criteria in Solid Tumours (RECIST) version 1.1 (Eisenhauer et al. Eur J Cancer 2009;45:228-47)

Indications marked with * are unapproved indications

Initial application — renal angiomyolipoma(s) associated with tuberous sclerosis complex*

Applications only from a nephrologist or urologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has tuberous sclerosis complex*
- and
- ☐ Evidence of renal angiomyolipoma(s) measuring 3 cm or greater and that have shown interval growth

Renewal — renal angiomyolipoma(s) associated with tuberous sclerosis complex*

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

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

Prerequisites(tick boxes where appropriate)

- ☐ Documented evidence of renal angiomyolipoma reduction or stability by magnetic resonance imaging (MRI) or ultrasound
- and
- ☐ Demonstrated stabilisation or improvement in renal function
- and
- ☐ The patient has not experienced angiomyolipoma haemorrhage or significant adverse effects to sirolimus treatment
- and
- ☐ The treatment remains appropriate and the patient is benefitting from treatment

Note: 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.

Signed: Date:

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz

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:

Sirolimus (Rapamune) - continued

Initial application — refractory seizures associated with tuberous sclerosis complex*

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has epilepsy with a background of documented tuberous sclerosis complex
and	
<input type="checkbox"/>	Vigabatrin has been trialed and has not adequately controlled seizures
and	
<input type="checkbox"/>	Seizures are not adequately controlled by, or the patient has experienced unacceptable side effects from, optimal treatment with at least two of the following: sodium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine, phenytoin sodium, and lacosamide (see Note)
or	
<input type="checkbox"/>	Vigabatrin is contraindicated
and	
<input type="checkbox"/>	Seizures are not adequately controlled by, or the patient has experienced unacceptable side effects from, optimal treatment with at least three of the following: sodium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine, phenytoin sodium, and lacosamide (see Note)
and	
<input type="checkbox"/>	Seizures have a significant impact on quality of life
and	
<input type="checkbox"/>	Patient has been assessed and surgery is considered inappropriate for this patient, or the patient has been assessed and would benefit from mTOR inhibitor treatment prior to surgery

Note: Those of childbearing age potential are not required to trial phenytoin sodium, sodium valproate, or topiramate. Those who can father children are not required to trial sodium valproate.

Renewal — refractory seizures associated with tuberous sclerosis complex*

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

Applications only from a neurologist. Approvals valid for 12 months.

Prerequisites(tick box where appropriate)

- ☐ Demonstrated significant and sustained improvement in seizure rate (e.g. 50% reduction in seizure frequency) or severity and/or patient quality of life compared with baseline prior to starting sirolimus treatment

Note: 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.

Signed: Date:

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz