

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:

Cetuximab

Initial application — head and neck cancer, locally advanced

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck
- and
- ☐ Cisplatin is contraindicated or has resulted in intolerable side effects
- and
- ☐ Patient has an ECOG performance score of 0-2
- and
- ☐ To be administered in combination with radiation therapy

Initial application — colorectal cancer, metastatic

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has metastatic colorectal cancer located on the left side of the colon (see Note)
- and
- ☐ There is documentation confirming disease is RAS and BRAF wild-type
- and
- ☐ Patient has an ECOG performance score of 0-2
- and
- ☐ Patient has not received prior funded treatment with cetuximab
- and
- ☐ Cetuximab is to be used in combination with chemotherapy

or

☐ Chemotherapy is determined to not be in the best interest of the patient based on clinician assessment

Renewal — colorectal cancer, metastatic

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

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

Prerequisites(tick box where appropriate)

- ☐ There is no evidence of disease progression

Note: Left-sided colorectal cancer comprises of the distal one-third of the transverse colon, the splenic flexure, the descending colon, the sigmoid colon, or the rectum.

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