

|                                                |                           |                               |
|------------------------------------------------|---------------------------|-------------------------------|
| <b>APPLICANT</b> (stamp or sticker acceptable) | <b>PATIENT</b> NHI: ..... | <b>REFERRER</b> Reg No: ..... |
| Reg No: .....                                  | First Names: .....        | First Names: .....            |
| Name: .....                                    | Surname: .....            | Surname: .....                |
| Address: .....                                 | DOB: .....                | Address: .....                |
| .....                                          | Address: .....            | .....                         |
| .....                                          | .....                     | .....                         |
| Fax Number: .....                              | .....                     | Fax Number: .....             |

## Gefitinib

### Initial application

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

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has locally advanced, or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC)  
and  

☐ Patient is treatment naive  
or  
☐ Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results  
or  

☐ The patient has discontinued osimertinib or erlotinib due to intolerance  
and  
☐ The cancer did not progress whilst on osimertinib or erlotinib
- and  
☐ There is documentation confirming that disease expresses activating mutations of EGFR

### Renewal

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

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

**Prerequisites**(tick box where appropriate)

- ☐ Radiological assessment (preferably including CT scan) indicates NSCLC has not progressed

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)