

|                                                |                           |                               |
|------------------------------------------------|---------------------------|-------------------------------|
| <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: .....             |

## Sunitinib

### Initial application — RCC

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

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has metastatic renal cell carcinoma
- and
- ☐ The patient has not previously received funded sunitinib

### Initial application — GIST

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 3 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has unresectable or metastatic malignant gastrointestinal stromal tumour (GIST)
- and
- ☐ The patient's disease has progressed following treatment with imatinib

or

☐ The patient has documented treatment-limiting intolerance, or toxicity to, imatinib

### Renewal — RCC

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

### Renewal — GIST

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

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

**Prerequisites**(tick boxes where appropriate)

**The patient has responded to treatment or has stable disease as determined by Choi's modified CT response evaluation criteria as follows:**

- ☐ The patient has had a complete response (disappearance of all lesions and no new lesions)
- or
- ☐ The patient has had a partial response (a decrease in size of 10% or more or decrease in tumour density in Hounsfield Units (HU) of 15% or more on CT and no new lesions and no obvious progression of non measurable disease)
- or
- ☐ The patient has stable disease (does not meet criteria the two above) and does not have progressive disease and no symptomatic deterioration attributed to tumour progression

- and
- ☐ The treatment remains appropriate and the patient is benefiting from treatment

Note: It is recommended that response to treatment be assessed using Choi's modified CT response evaluation criteria (J Clin Oncol, 2007, 25:1753-1759). Progressive disease is defined as either: an increase in tumour size of 10% or more and not meeting criteria of partial response (PR) by tumour density (HU) on CT; or: new lesions, or new intratumoral nodules, or increase in the size of the existing intratumoral nodules.

**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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| .....                                          | Address: .....            | .....                         |
| .....                                          | .....                     | .....                         |
| Fax Number: .....                              | .....                     | Fax Number: .....             |

**Sunitinib** - *continued*

**Renewal — GIST pandemic circumstances**

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

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

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has unresectable or metastatic malignant gastrointestinal stromal (GIST)

**and** ☐ The patient is clinically benefiting from treatment and continued treatment remains appropriate

**and** ☐ Sunitinib is to be discontinued at progression

**and** ☐ The regular Special Authority renewal requirements cannot be met due to COVID-19 constraints on the health sector

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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