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

## Cinacalcet

### Initial application — parathyroid carcinoma or calciphylaxis

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

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has been diagnosed with a parathyroid carcinoma (see Note)  
**and**  
☐ The patient has persistent hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) despite previous first-line treatments including sodium thiosulfate (where appropriate) and bisphosphonates  
**and**  
☐ The patient is symptomatic

- or**
- ☐ The patient has been diagnosed with calciphylaxis (calcific uraemic arteriopathy)  
**and**  
☐ The patient has symptomatic (e.g. painful skin ulcers) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L)  
**and**  
☐ The patient's condition has not responded to previous first-line treatments including bisphosphonates and sodium thiosulfate

### Renewal — parathyroid carcinoma or calciphylaxis

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

Applications only from a nephrologist or endocrinologist. Approvals valid without further renewal unless notified.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient's serum calcium level has fallen to < 3mmol/L  
**and**  
☐ The patient has experienced clinically significant symptom improvement

Note: This does not include parathyroid adenomas unless these have become malignant.

### Initial application — primary hyperparathyroidism

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

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has primary hyperparathyroidism  
**and**  

☐ Patient has hypercalcaemia of more than 3 mmol/L with or without symptoms  
**or**  
☐ Patient has hypercalcaemia of more than 2.85 mmol/L with symptoms

  
**and**  
☐ Surgery is not feasible or has failed  
**and**  
☐ Patient has other comorbidities, severe bone pain, or calciphylaxis

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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| .....                                          | .....                     | .....                         |
| Fax Number: .....                              | .....                     | Fax Number: .....             |

**Cinacalcet** - continued

**Initial application — secondary or tertiary hyperparathyroidism**

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

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has tertiary hyperparathyroidism and markedly elevated parathyroid hormone (PTH) with hypercalcaemia  
or  
☐ Patient has symptomatic secondary hyperparathyroidism and elevated PTH

and

- ☐ Patient is on renal replacement therapy

and

- ☐ Residual parathyroid tissue has not been localised despite repeat unsuccessful parathyroid explorations  
or  
☐ Parathyroid tissue is surgically inaccessible  
or  
☐ Parathyroid surgery is not feasible

**Renewal — secondary or tertiary hyperparathyroidism**

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

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

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has had a kidney transplant, and following a treatment free interval of at least 12 weeks a clinically acceptable parathyroid hormone (PTH) level to support ongoing cessation of treatment has not been reached  
or  
☐ The patient has not received a kidney transplant and trial of withdrawal of cinacalcet is clinically inappropriate

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)