

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

### Inotuzumab ozogamicin

#### Initial application

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has relapsed or refractory CD22-positive B-cell acute lymphoblastic leukaemia/lymphoma, including minimal residual disease
- and
- ☐ Patient has ECOG performance status of 0-2
- and
- ☐ Patient has Philadelphia chromosome positive B-Cell ALL

and

☐ Patient has previously received a tyrosine kinase inhibitor
- or
- ☐ Patient has received one prior line of treatment involving intensive chemotherapy
- and
- ☐ Treatment is to be administered for a maximum of 3 cycles

#### Renewal

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 4 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient is not proceeding to a stem cell transplant
- and
- ☐ Patient has experienced complete disease response

or

☐ Patient has experienced complete remission with incomplete haematological recovery
- and
- ☐ Treatment with inotuzumab ozogamicin is to cease after a total duration of 6 cycles

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)