

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:

Temozolomide

Initial application — gliomas

Applications only from a relevant specialist. Approvals valid for 12 months.

Prerequisites(tick box where appropriate)

☐ The patient has a glioma

Renewal — gliomas

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

Applications only from a relevant specialist. Approvals valid for 12 months.

Prerequisites(tick box where appropriate)

☐ Treatment remains appropriate and patient is benefitting from treatment

Initial application — neuroendocrine tumours

Applications only from a relevant specialist. Approvals valid for 9 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has been diagnosed with metastatic or unresectable well-differentiated neuroendocrine tumour*
- and
- ☐ Temozolomide is to be given in combination with capecitabine
- and
- ☐ Temozolomide is to be used in 28 day treatment cycles for a maximum of 5 days treatment per cycle at a maximum dose of 200 mg/m² per day
- and
- ☐ Temozolomide to be discontinued at disease progression

Renewal — neuroendocrine tumours

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

Applications only from a relevant specialist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ No evidence of disease progression
- and
- ☐ The treatment remains appropriate and the patient is benefitting from treatment

Initial application — ewing's sarcoma

Applications only from a relevant specialist. Approvals valid for 9 months.

Prerequisites(tick box where appropriate)

☐ The patient has relapsed/refractory Ewing's sarcoma

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

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Temozolomide - *continued*

Renewal — ewing's sarcoma

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

Applications only from a relevant specialist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ No evidence of disease progression

and

☐ The treatment remains appropriate and the patient is benefitting from treatment

Note: Indication marked with a * is an unapproved indication. Temozolomide is not subsidised for the treatment of relapsed high grade glioma.

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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