

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:

Crizotinib

Initial application

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

Prerequisites(tick boxes where appropriate)

- ☐ Patient has locally advanced or metastatic, unresectable, non-squamous non-small cell lung cancer
- and
- ☐ There is documentation confirming that the patient has a ROS1 rearrangement using an appropriate ROS1 test
- and
- ☐ Patient has ECOG performance score of 0-3
- and
- ☐ Baseline measurement of overall tumour burden is documented clinically and radiologically

Renewal

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

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

Prerequisites(tick boxes where appropriate)

- ☐ Response to treatment has been determined by comparable radiological assessment following the most recent treatment period
- and
- ☐ No evidence of disease progression.

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