

<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: .....

## Pegaspargase

### Initial application — Acute lymphoblastic leukaemia

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has newly diagnosed acute lymphoblastic leukaemia
- and
- ☐ Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol

### Initial application — Lymphoma

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

**Prerequisites**(tick box where appropriate)

- ☐ The patient has lymphoma requiring L-asparaginase containing protocols (e.g. SMILE)

### Renewal — Acute lymphoblastic leukaemia

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

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has relapsed acute lymphoblastic leukaemia
- and
- ☐ Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol

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)