

<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: .....
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Fax Number: .....	.....	Fax Number: .....

### Gemtuzumab ozogamicin

#### Initial application

Applications only from a haematologist, paediatric haematologist or paediatric oncologist. Approvals valid for 3 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has not received prior chemotherapy for this condition
- and
- ☐ Patient has de novo CD33-positive acute myeloid leukaemia
- and
- ☐ Patient does not have acute promyelocytic leukaemia
- and
- ☐ Gemtuzumab ozogamicin will be used in combination with standard anthracycline and cytarabine (AraC)
- and
- ☐ Patient is being treated with curative intent
- and
- ☐ Patient's disease risk has been assessed by cytogenetic testing to be good or intermediate
- and
- ☐ Patient must be considered eligible for standard intensive remission induction chemotherapy with standard anthracycline and cytarabine (AraC)
- and
- ☐ Gemtuzumab ozogamicin to be funded for one course only (one dose at 3 mg per m<sup>2</sup> body surface area or up to 2 vials of 5 mg as separate doses)

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

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)