Enquiries to Ministry of Health 0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:Palbociclib (Ibrance)		Fax Number:
Initial application Applications from any relevant practitioner. Approvals valid for 6 months. Prerequisites(tick boxes where appropriate) Patient has unresectable locally advanced or metastatic breast cancer		
and There is documentation confirming disease is hormone-receptor positive and HER2-negative and Patient has an ECOG performance score of 0-2 and		
Patient is amend without menstru and Patient has not a	or progressed during prior endocrine therapy orrhoeic, either naturally or induced, with endocrine leal-potential state received prior systemic treatment for metastatic disea	
and Treatment must be used in combination with an endocrine partner and Patient has not received prior funded treatment with a CDK4/6 inhibitor		
Patient has an active Special Authority approval for ribociclib and Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation and Treatment must be used in combination with an endocrine partner and There is no evidence of progressive disease since initiation of ribociclib		
Renewal Current approval Number (if known):		