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:		Fax Number:
lbrutinib		
Initial application — chronic lymphocytic leukaemia (CLL) Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Individual has chronic lymphocytic leukaemia (CLL) requiring therapy  Individual has not previously received funded ibrutinib  and Ibrutinib is to be used as monotherapy  and Individual has experienced intolerable side effects with venetoclax monotherapy  or Individual has experienced intolerable side effects with venetoclax monotherapy  or Individual's CLL has relapsed  and Individual's CLL has relapsed side effects with venetoclax in combination with rituximab regimen  or Individual's CLL is refractory to or has relapsed following a venetoclax regimen  Renewal — chronic lymphocytic leukaemia (CLL)  Current approval Number (if known):		
There is no evidence of disease progression		
Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)*. Indications		

marked with \* are Unapproved indications.

I confirm the above details are correct and that in signing this form I understand I may be audited.