

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:

Atezolizumab

Initial application — non-small cell lung cancer second line monotherapy

Applications only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has locally advanced or metastatic non-small cell lung cancer
- and
- ☐ Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC
- and
- ☐ For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain
- and
- ☐ Patient has an ECOG 0-2
- and
- ☐ Patient has documented disease progression following treatment with at least two cycles of platinum-based chemotherapy
- and
- ☐ Atezolizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a maximum of 16 weeks
- and
- ☐ Baseline measurement of overall tumour burden is documented clinically and radiologically

Renewal — non-small cell lung cancer second line monotherapy

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

Applications only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient's disease has had a complete response to treatment
- or
- ☐ Patient's disease has had a partial response to treatment
- or
- ☐ Patient has stable disease
- and
- ☐ Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period
- and
- ☐ No evidence of disease progression
- and
- ☐ The treatment remains clinically appropriate and patient is benefitting from treatment
- and
- ☐ Atezolizumab to be used at a maximum dose of 1200 mg every three weeks (or equivalent)
- and
- ☐ Treatment with atezolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)

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

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:

Atezolizumab - continued

Initial application — unresectable hepatocellular carcinoma

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

Prerequisites(tick boxes where appropriate)

- ☐ Patient is currently on treatment with atezolizumab and met all remaining criteria prior to commencing treatment
- or
- ☐ Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma

and

☐ Patient has preserved liver function (Child-Pugh A)

and

☐ Transarterial chemoembolisation (TACE) is unsuitable

and

☐ Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma

or

☐ Patient received funded lenvatinib before 1 March 2025

or

☐ Patient has experienced treatment-limiting toxicity from treatment with lenvatinib

and

☐ No disease progression since initiation of lenvatinib
- and
- ☐ Patient has an ECOG performance status of 0-2
- and
- ☐ To be given in combination with bevacizumab

Renewal — unresectable hepatocellular carcinoma

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

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

Prerequisites(tick box where appropriate)

- ☐ There is 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