

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:

Pazopanib

Initial application

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

☐ The patient has metastatic renal cell carcinoma of predominantly clear cell histology

and

☐ The patient is treatment naive

or

☐ The patient has only received prior cytokine treatment

and

☐ The patient has an ECOG performance score of 0-2

and

The patient has intermediate or poor prognosis defined as:

☐ Lactate dehydrogenase level > 1.5 times upper limit of normal

or

☐ Haemoglobin level < lower limit of normal

or

☐ Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)

or

☐ Interval of < 1 year from original diagnosis to the start of systemic therapy

or

☐ Karnofsky performance score of less than or equal to 70

or

☐ 2 or more sites of organ metastasis

and

☐ Pazopanib to be used for a maximum of 3 months

or

☐ The patient has metastatic renal cell carcinoma

and

☐ The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance

and

☐ The cancer did not progress whilst on sunitinib

and

☐ Pazopanib to be used for a maximum of 3 months

Renewal

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

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 3 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