

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:

Pegylated Interferon alfa-2A

Initial application — chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant

Applications from any specialist. Approvals valid for 18 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection
or
☐ Patient has chronic hepatitis C and is co-infected with HIV
or
☐ Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant

and

- ☐ Maximum of 48 weeks therapy

Renewal — Chronic hepatitis C - genotype 1 infection

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

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 1
and
☐ Patient has had previous treatment with pegylated interferon and ribavirin
and

☐ Patient has responder relapsed
or
☐ Patient was a partial responder

and

- ☐ Patient is to be treated in combination with boceprevir

and

- ☐ Maximum of 48 weeks therapy

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

Signed: Date:

Post application to Health New Zealand, 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:

Pegylated Interferon alfa-2A - *continued*

Initial application — Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 1
- and
- ☐ Patient has had previous treatment with pegylated interferon and ribavirin
- and
- ☐ Patient has responder relapsed

or

☐ Patient was a partial responder

or

☐ Patient received interferon treatment prior to 2004
- and
- ☐ Patient is to be treated in combination with boceprevir
- and
- ☐ Maximum of 48 weeks therapy

Initial application — chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV

Applications from any specialist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 2 or 3 infection
- and
- ☐ Maximum of 6 months therapy

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

Signed: Date:

Post application to Health New Zealand, 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:

Pegylated Interferon alfa-2A - continued

Initial application — Hepatitis B

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has confirmed Hepatitis B infection (HBsAg positive for more than 6 months)
- and
- ☐ Patient is Hepatitis B treatment-naïve
- and
- ☐ ALT > 2 times Upper Limit of Normal
- and
- ☐ HBV DNA < 10 log₁₀ IU/ml
- and
- ☐ HBeAg positive

or

☐ Serum HBV DNA greater than or equal to 2,000 units/ml and significant fibrosis (Metavir Stage F2 or greater or moderate fibrosis)
- and
- ☐ Compensated liver disease
- and
- ☐ No continuing alcohol abuse or intravenous drug use
- and
- ☐ Not co-infected with HCV, HIV or HDV
- and
- ☐ Neither ALT nor AST > 10 times upper limit of normal
- and
- ☐ No history of hypersensitivity or contraindications to pegylated interferon
- and
- ☐ Maximum of 48 weeks therapy

Initial application — myeloproliferative disorder or cutaneous T cell lymphoma

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has a cutaneous T cell lymphoma*
- or
- ☐ Patient has a myeloproliferative disorder*

and

☐ Patient is intolerant of hydroxyurea

and

☐ Treatment with anagrelide and busulfan is not clinically appropriate
- or
- ☐ Patient has a myeloproliferative disorder

and

☐ Patient is pregnant, planning pregnancy or lactating

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

Signed: Date:

Post application to Health New Zealand, 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:

Pegylated Interferon alfa-2A - continued

Renewal — myeloproliferative disorder or cutaneous T cell lymphoma

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- ☐ No evidence of disease progression
- and
- ☐ The treatment remains appropriate and patient is benefitting from treatment
- and
- ☐ Patient has a cutaneous T cell lymphoma*
- or
- ☐ Patient has a myeloproliferative disorder*
- and
- ☐ Remains intolerant of hydroxyurea and treatment with anagrelide and busulfan remains clinically inappropriate
- or
- ☐ Patient is pregnant, planning pregnancy or lactating

Note: Indications marked with * are unapproved indications.

Initial application — post-allogeneic bone marrow transplant

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick box where appropriate)

- ☐ Patient has received an allogeneic bone marrow transplant* and has evidence of disease relapse

Renewal — post-allogeneic bone marrow transplant

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

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick box where appropriate)

- ☐ Patient is responding and ongoing treatment remains appropriate

Note: 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.

Signed: Date:

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz