

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT</b> NHI: .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
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Fax Number: .....	.....	Fax Number: .....

## Cetuximab

### Initial application — head and neck cancer, locally advanced

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck
- and
- ☐ Cisplatin is contraindicated or has resulted in intolerable side effects
- and
- ☐ Patient has an ECOG performance score of 0-2
- and
- ☐ To be administered in combination with radiation therapy

### Initial application — colorectal cancer, metastatic

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has metastatic colorectal cancer located on the left side of the colon (see Note)
- and
- ☐ There is documentation confirming disease is RAS and BRAF wild-type
- and
- ☐ Patient has an ECOG performance score of 0-2
- and
- ☐ Patient has not received prior funded treatment with cetuximab
- and
- ☐ Cetuximab is to be used in combination with chemotherapy

or

☐ Chemotherapy is determined to not be in the best interest of the patient based on clinician assessment

### Renewal — colorectal cancer, metastatic

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 6 months.

**Prerequisites**(tick box where appropriate)

- ☐ There is no evidence of disease progression

Note: Left-sided colorectal cancer comprises of the distal one-third of the transverse colon, the splenic flexure, the descending colon, the sigmoid colon, or the rectum.

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](mailto:customerservice@health.govt.nz)