

<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: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

### Abiraterone acetate

#### Initial application

Applications only from a medical oncologist, radiation oncologist, urologist or medical practitioner on the recommendation of a medical oncologist, radiation oncologist or urologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has prostate cancer  
and  
☐ Patient has metastases  
and  
☐ Patient's disease is castration resistant  
and
- ☐ Patient is symptomatic  
and  
☐ Patient has disease progression (rising serum PSA) after second line anti-androgen therapy  
and  
☐ Patient has ECOG performance score of 0-1  
and  
☐ Patient has not had prior treatment with taxane chemotherapy

or  

☐ Patient's disease has progressed following prior chemotherapy containing a taxane  
and  
☐ Patient has ECOG performance score of 0-2  
and  
☐ Patient has not had prior treatment with abiraterone

#### Renewal — abiraterone acetate

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

Applications only from a medical oncologist, radiation oncologist, urologist or medical practitioner on the recommendation of a medical oncologist, radiation oncologist or urologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Significant decrease in serum PSA from baseline  
and  
☐ No evidence of clinical disease progression  
and  
☐ No initiation of taxane chemotherapy with abiraterone  
and  
☐ The treatment remains appropriate and the patient is benefiting from treatment

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)

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**Abiraterone acetate** - continued

**Renewal — pandemic circumstances**

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

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

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient is clinically benefiting from treatment and continued treatment remains appropriate

and ☐ Abiraterone acetate to be discontinued at progression

and ☐ No initiation of taxane chemotherapy with abiraterone

and ☐ The regular Special Authority renewal requirements cannot be met due to COVID-19 constraints on the health sector

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

Signed: ..... Date: .....

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