

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:

Midostaurin

Initial application

Applications from any relevant practitioner. Approvals valid for 9 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has a diagnosis of acute myeloid leukaemia
- and
- ☐ Condition must be FMS tyrosine kinase 3 (FLT3) mutation positive
- and
- ☐ Patient must not have received a prior line of intensive chemotherapy for acute myeloid leukaemia
- and
- ☐ Patient is to receive standard intensive chemotherapy in combination with midostaurin only
- and
- ☐ Midostaurin to be funded for a maximum of 4 cycles

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