

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:

Palbociclib (Ibrance)

Initial application

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

Prerequisites(tick boxes where appropriate)

- ☐ Patient has unresectable locally advanced or metastatic breast cancer
and
☐ There is documentation confirming disease is hormone-receptor positive and HER2-negative
and
☐ Patient has an ECOG performance score of 0-2
and

☐ Disease has relapsed or progressed during prior endocrine therapy
or

☐ Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state
and
☐ Patient has not received prior systemic treatment for metastatic disease

and
☐ Treatment must be used in combination with an endocrine partner
and
☐ Patient has not received prior funded treatment with a CDK4/6 inhibitor
- or

☐ Patient has an active Special Authority approval for ribociclib
and
☐ Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation
and
☐ Treatment must be used in combination with an endocrine partner
and
☐ There is no evidence of progressive disease since initiation of ribociclib

Renewal

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

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

Prerequisites(tick boxes where appropriate)

- ☐ Treatment must be used in combination with an endocrine partner
and
☐ There is no evidence of progressive disease since initiation of palbociclib

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