

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:

Bevacizumab

Initial application — unresectable hepatocellular carcinoma

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

Prerequisites(tick boxes where appropriate)

- ☐ Patient is currently on treatment with bevacizumab, and met all remaining criteria prior to commencing treatment
- or
- ☐ Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma

and

☐ Patient has preserved liver function (Child-Pugh A)

and

☐ Transarterial chemoembolisation (TACE) is unsuitable

and

☐ Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma

or

☐ Patient received funded lenvatinib before 1 March 2025

or

☐ Patient has experienced treatment-limiting toxicity from treatment with lenvatinib

and

☐ No disease progression since initiation of lenvatinib
- and
- ☐ Patient has an ECOG performance status of 0-2
- and
- ☐ To be given in combination with atezolizumab

Renewal — unresectable hepatocellular carcinoma

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

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

Prerequisites(tick box where appropriate)

- ☐ There is no evidence of disease progression

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:

Bevacizumab - continued

Initial application — advanced or metastatic ovarian cancer

Applications from any relevant practitioner. Approvals valid for 4 months.

Prerequisites(tick boxes where appropriate)

- ☐ The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer
- or
- ☐ The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary peritoneal cancer
- and
- ☐ Debulking surgery is inappropriate
- or
- ☐ The cancer is sub-optimally debulked (maximum diameter of any gross residual disease greater than 1cm)
- and
- ☐ Bevacizumab to be administered at a maximum dose of 15 mg/kg every three weeks
- and
- ☐ 18 weeks concurrent treatment with chemotherapy is planned

Renewal — advanced or metastatic ovarian cancer

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

Applications from any relevant practitioner. Approvals valid for 4 months.

Prerequisites(tick box where appropriate)

- ☐ There is no evidence of disease progression

Initial application — Recurrent Respiratory Papillomatosis

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

Prerequisites(tick boxes where appropriate)

- ☐ Maximum of 6 doses
- and
- ☐ The patient has recurrent respiratory papillomatosis
- and
- ☐ The treatment is for intra-lesional administration

Renewal — Recurrent Respiratory Papillomatosis

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

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

Prerequisites(tick boxes where appropriate)

- ☐ Maximum of 6 doses
- and
- ☐ The treatment is for intra-lesional administration
- and
- ☐ There has been a reduction in surgical treatments or disease regrowth as a result of 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

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:

Bevacizumab - *continued*

Initial application — Ocular Conditions

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

- ☐ Ocular neovascularisation
- or
- ☐ Exudative ocular angiopathy

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