

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

## Ibrutinib

### Initial application — chronic lymphocytic leukaemia (CLL)

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

**Prerequisites**(tick boxes where appropriate)

- ☐ Individual has chronic lymphocytic leukaemia (CLL) requiring therapy
- and
- ☐ Individual has not previously received funded ibrutinib
- and
- ☐ Ibrutinib is to be used as monotherapy
- and
- ☐ There is documentation confirming that the individual has 17p deletion or TP53 mutation

and

☐ Individual has experienced intolerable side effects with venetoclax monotherapy
- or
- ☐ Individual has received at least one prior immunochemotherapy for CLL

and

☐ Individual's CLL has relapsed

and

☐ Individual has experienced intolerable side effects with venetoclax in combination with rituximab regimen
- or
- ☐ Individual's CLL is refractory to or has relapsed following a venetoclax regimen

### Renewal — chronic lymphocytic leukaemia (CLL)

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

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

**Prerequisites**(tick box where appropriate)

- ☐ There is no evidence of disease progression

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)\*. Indications marked with \* are Unapproved indications.

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)