

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

## Ruxolitinib

### Initial application

Applications only from a haematologist. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis
- and
- ☐ A classification of risk of intermediate-2 or high-risk myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS
- or
- ☐ A classification of risk of intermediate-1 myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS

and

☐ Patient has severe disease-related symptoms that are resistant, refractory or intolerant to available therapy
- and
- ☐ A maximum dose of 20 mg twice daily is to be given

### Renewal

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

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment
- and
- ☐ A maximum dose of 20 mg twice daily is to be given

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)