

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

### **Fulvestrant**

#### **Initial application**

Applications only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 6 months.

#### **Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer
<b>and</b>	
<input type="checkbox"/>	Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease
<b>and</b>	
<input type="checkbox"/>	Treatment to be given at a dose of 500 mg monthly following loading doses
<b>and</b>	
<input type="checkbox"/>	Treatment to be discontinued at disease progression

#### **Renewal**

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

Applications only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 6 months.

#### **Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Treatment remains appropriate and patient is benefitting from treatment
<b>and</b>	
<input type="checkbox"/>	Treatment to be given at a dose of 500 mg monthly
<b>and</b>	
<input type="checkbox"/>	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](mailto:customerservice@health.govt.nz)