

|  |                           |                               |
|--|---------------------------|-------------------------------|
| <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: .....                |
| .....  | Address: .....            | .....                         |
| .....  | .....                     | .....                         |
| Fax Number: .....                              | .....                     | Fax Number: .....             |

## Pegfilgrastim

### Initial application

Applications only from a relevant specialist, vocationally registered general practitioner or medical practitioner on the recommendation of a relevant specialist. Approvals valid without further renewal unless notified.

### Prerequisites (tick box where appropriate)

☐ Used for prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 5%\*)

Note: \*Febrile neutropenia risk greater than or equal to 5% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines.

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)