

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:

Brentuximab

Initial application — relapsed/refractory Hodgkin lymphoma

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

Prerequisites(tick boxes where appropriate)

☐ Patient has relapsed/refractory CD30-positive Hodgkin lymphoma after two or more lines of chemotherapy
and
☐ Patient is ineligible for autologous stem cell transplant

or

☐ Patient has relapsed/refractory CD30-positive Hodgkin lymphoma
and
☐ Patient has previously undergone autologous stem cell transplant

and

☐ Patient has not previously received funded brentuximab vedotin

and

☐ Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles

and

☐ Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks

Renewal — relapsed/refractory Hodgkin lymphoma

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

Applications from any relevant practitioner. Approvals valid for 9 months.

Prerequisites(tick boxes where appropriate)

☐ Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles
and
☐ Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated
and
☐ Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment

Initial application — anaplastic large cell lymphoma

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

Prerequisites(tick boxes where appropriate)

☐ Patient has relapsed/refractory CD30-positive systemic anaplastic large cell lymphoma
and
☐ Patient has an ECOG performance status of 0-1
and
☐ Patient has not previously received brentuximab vedotin
and
☐ Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles
and
☐ Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks

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

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Name:	Surname:	Surname:
Address:	DOB:	Address:
.....	Address:
.....
Fax Number:	Fax Number:

Brentuximab - *continued*

Renewal — anaplastic large cell lymphoma

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

Applications from any relevant practitioner. Approvals valid for 9 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles

and ☐ Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated

and ☐ Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment

I confirm the above details are correct and that in signing this form I understand I may be audited.

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