

<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: .....	

## Niraparib

### Initial application

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

#### Prerequisites (tick boxes where appropriate)

Patient has advanced high-grade serous\* epithelial ovarian, fallopian tube, or primary peritoneal cancer  
and  Patient has received at least one line\*\* of treatment with platinum-based chemotherapy  
and  Patient has experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy  
and  Patient has not previously received funded treatment with a PARP inhibitor  
and  Treatment will be commenced within 12 weeks of the patient's last dose of the preceding platinum-based regimen  
or  Patient commenced treatment with niraparib prior to 1 May 2024  
and  Treatment to be administered as maintenance treatment  
and  Treatment not to be administered in combination with other chemotherapy

### Renewal

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

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

#### Prerequisites (tick boxes where appropriate)

No evidence of progressive disease  
and  Treatment to be administered as maintenance treatment  
and  Treatment not to be administered in combination with other chemotherapy  
and  Treatment with niraparib to cease after a total duration of 36 months from commencement  
or  Treatment with niraparib is being used in the second-line or later maintenance setting

Note: \* "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component.

\*\*A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments

**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)