

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:

Lenalidomide

Initial application — Plasma cell dyscrasia

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

Patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment
and
 Patient is not refractory to prior lenalidomide use

Initial application — Myelodysplastic syndrome

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

Prerequisites(tick boxes where appropriate)

Patient has low or intermediate-1 risk myelodysplastic syndrome (based on IPSS or an IPSS-R score of less than 3.5) associated with a deletion 5q cytogenetic abnormality
and
 Patient has transfusion-dependent anaemia

Renewal — Myelodysplastic syndrome

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

Patient has not needed a transfusion in the last 4 months
and
 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