

<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: .....	

### **Atezolizumab**

#### **Initial application — non-small cell lung cancer second line monotherapy**

Applications only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient has locally advanced or metastatic non-small cell lung cancer	
<b>and</b>	<input type="checkbox"/>	Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC
<b>and</b>	<input type="checkbox"/>	For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain
<b>and</b>	<input type="checkbox"/>	Patient has an ECOG 0-2
<b>and</b>	<input type="checkbox"/>	Patient has documented disease progression following treatment with at least two cycles of platinum-based chemotherapy
<b>and</b>	<input type="checkbox"/>	Atezolizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a maximum of 16 weeks
<b>and</b>	<input type="checkbox"/>	Baseline measurement of overall tumour burden is documented clinically and radiologically

#### **Renewal — non-small cell lung cancer second line monotherapy**

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

Applications only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient's disease has had a complete response to treatment	
<b>or</b>	<input type="checkbox"/>	Patient's disease has had a partial response to treatment
<b>or</b>	<input type="checkbox"/>	Patient has stable disease
<b>and</b>	<input type="checkbox"/>	Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period
<b>and</b>	<input type="checkbox"/>	No evidence of disease progression
<b>and</b>	<input type="checkbox"/>	The treatment remains clinically appropriate and patient is benefitting from treatment
<b>and</b>	<input type="checkbox"/>	Atezolizumab to be used at a maximum dose of 1200 mg every three weeks (or equivalent)
<b>and</b>	<input type="checkbox"/>	Treatment with atezolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed 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](mailto:customerservice@health.govt.nz)

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**Atezolizumab** - *continued*

**Initial application — unresectable hepatocellular carcinoma**

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

**Prerequisites**(tick boxes where appropriate)

Patient is currently on treatment with atezolizumab and met all remaining criteria prior to commencing treatment

or

Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma

and

Patient has preserved liver function (Child-Pugh A)

and

Transarterial chemoembolisation (TACE) is unsuitable

and

Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma

or

Patient received funded lenvatinib before 1 March 2025

or

Patient has experienced treatment-limiting toxicity from treatment with lenvatinib

and

No disease progression since initiation of lenvatinib

and

Patient has an ECOG performance status of 0-2

and

To be given in combination with bevacizumab

**Renewal — unresectable hepatocellular carcinoma**

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

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

**Prerequisites**(tick box where appropriate)

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.**

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