

<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: .....	.....
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Fax Number: .....	.....	Fax Number: .....

### Long-acting Somatostatin Analogues

#### Initial application — Malignant Bowel Obstruction

Applications from any relevant practitioner. Approvals valid for 2 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has nausea\* and vomiting\* due to malignant bowel obstruction\*
- and
- ☐ Treatment with antiemetics, rehydration, antimuscarinic agents, corticosteroids and analgesics for at least 48 hours has not been successful
- and
- ☐ Treatment to be given for up to 4 weeks

Note: Indications marked with \* are unapproved indications.

#### Renewal — Malignant Bowel Obstruction

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

Applications from any relevant practitioner. Approvals valid for 3 months.

**Prerequisites**(tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

#### Initial application — Acromegaly

Applications from any relevant practitioner. Approvals valid for 3 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has acromegaly
- and
- ☐ Treatment with surgery and radiotherapy is not suitable or was unsuccessful

or

☐ Treatment is for an interim period while awaiting the beneficial effects of radiotherapy
- and
- ☐ Treatment with a dopamine agonist has been unsuccessful

#### Renewal — Acromegaly

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

Applications from any relevant practitioner. Approvals valid for 2 years.

**Prerequisites**(tick box where appropriate)

- ☐ IGF1 levels have decreased since starting treatment

Note: In patients with acromegaly, treatment should be discontinued if IGF1 levels have not decreased 3 months after treatment. In patients treated with radiotherapy treatment should be withdrawn every 2 years, for 1 month, for assessment of remission. Treatment should be stopped where there is biochemical evidence of remission (normal IGF1 levels) following treatment withdrawal for at least 4 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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**Long-acting Somatostatin Analogues - continued**

**Initial application — pre-operative acromegaly**

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

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has acromegaly
- and
- ☐ Patient has a large pituitary tumour, greater than 10 mm at its widest
- and
- ☐ Patient is scheduled to undergo pituitary surgery in the next six months

**Initial application — Other Indications**

Applications from any relevant practitioner. Approvals valid for 2 years.

**Prerequisites**(tick boxes where appropriate)

- ☐ VIPomas and Glucagonomas - for patients who are seriously ill in order to improve their clinical state prior to definitive surgery
- or
- ☐ Gastrinoma

and

☐ Surgery has been unsuccessful

or

☐ Patient has metastatic disease after treatment with H2 antagonist or proton pump inhibitors has been unsuccessful

or

☐ Insulinomas

and

☐ Surgery is contraindicated or has not been successful

or

☐ For pre-operative control of hypoglycaemia and for maintenance therapy

or

☐ Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis)

and

☐ Disabling symptoms not controlled by maximal medical therapy

Note: The use of a long-acting somatostatin analogue in patients with fistulae, oesophageal varices, miscellaneous diarrhoea and hypotension will not be funded under Special Authority

**Renewal — Other Indications**

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

Applications from any relevant practitioner. Approvals valid for 2 years.

**Prerequisites**(tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

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

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