

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:

Azacitidine

Initial application

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

Prerequisites(tick boxes where appropriate)

or The individual has intermediate or high risk MDS based on an internationally recognised scoring system

or The individual has chronic myelomonocytic leukaemia (based on an intermediate or high risk score from an internationally recognised scoring system or 10%-29% marrow blasts without myeloproliferative disorder)

The individual has acute myeloid leukaemia according to World Health Organisation Classification (WHO)

and

The individual has an estimated life expectancy of at least 3 months

Renewal

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

Applications from any relevant practitioner. Approvals valid for 12 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.

Signed: Date:

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz