

| | | |
|--|---------------------------|-------------------------------|
| 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: |

Bevacizumab

Initial application — unresectable hepatocellular carcinoma

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

Prerequisites(tick boxes where appropriate)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Patient is currently on treatment with bevacizumab, and met all remaining criteria prior to commencing treatment |
| or | |
| <input type="checkbox"/> | Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma |
| and | |
| <input type="checkbox"/> | Patient has preserved liver function (Child-Pugh A) |
| and | |
| <input type="checkbox"/> | Transarterial chemoembolisation (TACE) is unsuitable |
| and | |
| <input type="checkbox"/> | Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma |
| or | |
| <input type="checkbox"/> | Patient received funded lenvatinib before 1 March 2025 |
| or | |
| <input type="checkbox"/> | Patient has experienced treatment-limiting toxicity from treatment with lenvatinib |
| and | |
| <input type="checkbox"/> | No disease progression since initiation of lenvatinib |
| and | |
| <input type="checkbox"/> | Patient has an ECOG performance status of 0-2 |
| and | |
| <input type="checkbox"/> | To be given in combination with atezolizumab |

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.

Signed: Date:

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

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..... Address:

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Bevacizumab - continued

Initial application — advanced or metastatic ovarian cancer

Applications from any relevant practitioner. Approvals valid for 4 months.

Prerequisites(tick boxes where appropriate)

The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer

or

The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary peritoneal cancer

and

Debulking surgery is inappropriate

or

The cancer is sub-optimally debulked (maximum diameter of any gross residual disease greater than 1cm)

and

Bevacizumab to be administered at a maximum dose of 15 mg/kg every three weeks

and

18 weeks concurrent treatment with chemotherapy is planned

Renewal — advanced or metastatic ovarian cancer

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

Applications from any relevant practitioner. Approvals valid for 4 months.

Prerequisites(tick box where appropriate)

There is no evidence of disease progression

Initial application — Recurrent Respiratory Papillomatosis

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

Prerequisites(tick boxes where appropriate)

Maximum of 6 doses

and

The patient has recurrent respiratory papillomatosis

and

The treatment is for intra-lesional administration

Renewal — Recurrent Respiratory Papillomatosis

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

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

Prerequisites(tick boxes where appropriate)

Maximum of 6 doses

and

The treatment is for intra-lesional administration

and

There has been a reduction in surgical treatments or disease regrowth as a result of treatment

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

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Bevacizumab - *continued*

Initial application — Ocular Conditions

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

Prerequisites(tick boxes where appropriate)

| |
|--|
| <input type="checkbox"/> Ocular neovascularisation |
| or |
| <input type="checkbox"/> Exudative ocular angiopathy |

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