

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:

Ribociclib

Initial application

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

Prerequisites(tick boxes where appropriate)

Patient has unresectable locally advanced or metastatic breast cancer

and

There is documentation confirming disease is hormone-receptor positive and HER2-negative

and

Patient has an ECOG performance score of 0-2

and

Disease has relapsed or progressed during prior endocrine therapy

or

Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state

and

Patient has not received prior systemic endocrine treatment for metastatic disease

and

Treatment to be used in combination with an endocrine partner

and

Patient has not received prior funded treatment with a CDK4/6 inhibitor

or

Patient has an active Special Authority approval for palbociclib

and

Patient has experienced a grade 3 or 4 adverse reaction to palbociclib that cannot be managed by dose reductions and requires treatment discontinuation

and

Treatment must be used in combination with an endocrine partner

and

There is no evidence of progressive disease since initiation of palbociclib

Renewal

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

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

Prerequisites(tick boxes where appropriate)

Treatment must be used in combination with an endocrine partner

and

There is no evidence of progressive disease since initiation of ribociclib

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