

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:

Obinutuzumab

Initial application — chronic lymphocytic leukaemia

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

Prerequisites(tick boxes where appropriate)

The patient has progressive Binet stage A, B or C CD20+ chronic lymphocytic leukaemia requiring treatment

and

The patient is obinutuzumab treatment naive

and

The patient is not eligible for full dose FCR due to comorbidities with a score > 6 on the Cumulative Illness Rating Scale (CIRS) or reduced renal function (creatinine clearance < 70mL/min)

and

Patient has adequate neutrophil and platelet counts* unless the cytopenias are a consequence of marrow infiltration by CLL

and

Patient has good performance status

and

Obinutuzumab to be administered at a maximum cumulative dose of 8,000 mg and in combination with chlorambucil for a maximum of 6 cycles

Note: Chronic lymphocytic leukaemia includes small lymphocytic lymphoma. Comorbidity refers only to illness/impairment other than CLL induced illness/impairment in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2.

* Neutrophil greater than or equal to $1.5 \times 10^9/L$ and platelets greater than or equal to $75 \times 10^9/L$.

Initial application — follicular / marginal zone lymphoma

Applications from any relevant practitioner. Approvals valid for 9 months.

Prerequisites(tick boxes where appropriate)

Patient has follicular lymphoma

or

Patient has marginal zone lymphoma

and

Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen*

and

Patient has an ECOG performance status of 0-2

and

Patient has been previously treated with no more than four chemotherapy regimens

and

Obinutuzumab to be administered at a maximum dose of 1000 mg for a maximum of 6 cycles in combination with chemotherapy*

Note: * includes unapproved indications

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

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:

Obinutuzumab - *continued*

Renewal — follicular / marginal zone lymphoma

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

Applications from any relevant practitioner. Approvals valid for 24 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has no evidence of disease progression following obinutuzumab induction therapy
and	<input type="checkbox"/>
<input type="checkbox"/>	Obinutuzumab to be administered at a maximum of 1000 mg every 2 months for a maximum of 2 years
and	<input type="checkbox"/>
<input type="checkbox"/>	Obinutuzumab to be discontinued at 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