

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:

Pazopanib

Initial application

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months.

Prerequisites(tick boxes where appropriate)

The patient has metastatic renal cell carcinoma of predominantly clear cell histology

and

The patient is treatment naive

or

The patient has only received prior cytokine treatment

and

The patient has an ECOG performance score of 0-2

and

The patient has intermediate or poor prognosis defined as:

Lactate dehydrogenase level > 1.5 times upper limit of normal

or

Haemoglobin level < lower limit of normal

or

Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)

or

Interval of < 1 year from original diagnosis to the start of systemic therapy

or

Karnofsky performance score of less than or equal to 70

or

2 or more sites of organ metastasis

and

Pazopanib to be used for a maximum of 3 months

or

The patient has metastatic renal cell carcinoma

and

The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance

and

The cancer did not progress whilst on sunitinib

and

Pazopanib to be used for a maximum of 3 months

Renewal

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

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 3 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