

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:

Alectinib

Initial application

Applications only from a medical oncologist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has locally advanced, or metastatic, unresectable, non-small cell lung cancer
- and
- ☐ There is documentation confirming that the patient has an ALK tyrosine kinase gene rearrangement using an appropriate ALK test
- and
- ☐ Patient has an ECOG performance score of 0-2

Renewal

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

Applications only from a medical oncologist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ No evidence of progressive disease according to RECIST criteria
- and
- ☐ The patient is benefitting from and tolerating treatment

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