

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:

Fulvestrant

Initial application

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

Prerequisites(tick boxes where appropriate)

- ☐ Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer
- and
- ☐ Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease
- and
- ☐ Treatment to be given at a dose of 500 mg monthly following loading doses
- and
- ☐ Treatment to be discontinued at disease progression

Renewal

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

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

Prerequisites(tick boxes where appropriate)

- ☐ Treatment remains appropriate and patient is benefitting from treatment
- and
- ☐ Treatment to be given at a dose of 500 mg monthly
- and
- ☐ 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