

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:

Gemtuzumab ozogamicin

Initial application

Applications only from a haematologist, paediatric haematologist or paediatric oncologist. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has not received prior chemotherapy for this condition
and ☐ Patient has de novo CD33-positive acute myeloid leukaemia
and ☐ Patient does not have acute promyelocytic leukaemia
and ☐ Gemtuzumab ozogamicin will be used in combination with standard anthracycline and cytarabine (AraC)
and ☐ Patient is being treated with curative intent
and ☐ Patient's disease risk has been assessed by cytogenetic testing to be good or intermediate
and ☐ Patient must be considered eligible for standard intensive remission induction chemotherapy with standard anthracycline and cytarabine (AraC)
and ☐ Gemtuzumab ozogamicin to be funded for one course only (one dose at 3 mg per m² body surface area or up to 2 vials of 5 mg as separate doses)

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

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