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|------------------------------------------------|---------------------------|-------------------------------|
| <b>APPLICANT</b> (stamp or sticker acceptable) | <b>PATIENT</b> NHI: ..... | <b>REFERRER</b> Reg No: ..... |
| Reg No: .....                                  | First Names: .....        | First Names: .....            |
| Name: .....                                    | Surname: .....            | Surname: .....                |
| Address: .....                                 | DOB: .....                | Address: .....                |
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| Fax Number: .....                              | .....                     | Fax Number: .....             |

## Bevacizumab

### Initial application — unresectable hepatocellular carcinoma

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient is currently on treatment with bevacizumab, and met all remaining criteria prior to commencing treatment
- or
- ☐ Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma

and

☐ Patient has preserved liver function (Child-Pugh A)

and

☐ Transarterial chemoembolisation (TACE) is unsuitable

and

☐ Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma

or

☐ Patient received funded lenvatinib before 1 March 2025

or

☐ Patient has experienced treatment-limiting toxicity from treatment with lenvatinib

and

☐ No disease progression since initiation of lenvatinib
- and
- ☐ Patient has an ECOG performance status of 0-2
- and
- ☐ To be given in combination with atezolizumab

### Renewal — unresectable hepatocellular carcinoma

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

Applications from any relevant practitioner. Approvals valid for 6 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](mailto:customerservice@health.govt.nz)

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**Bevacizumab** - continued

**Initial application — advanced or metastatic ovarian cancer**

Applications from any relevant practitioner. Approvals valid for 4 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer
- or
- ☐ The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary peritoneal cancer

and

☐ Debulking surgery is inappropriate

or

☐ The cancer is sub-optimally debulked (maximum diameter of any gross residual disease greater than 1cm)
- and
- ☐ Bevacizumab to be administered at a maximum dose of 15 mg/kg every three weeks
- and
- ☐ 18 weeks concurrent treatment with chemotherapy is planned

**Renewal — advanced or metastatic ovarian cancer**

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

Applications from any relevant practitioner. Approvals valid for 4 months.

**Prerequisites**(tick box where appropriate)

- ☐ There is no evidence of disease progression

**Initial application — Recurrent Respiratory Papillomatosis**

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

**Prerequisites**(tick boxes where appropriate)

- ☐ Maximum of 6 doses
- and
- ☐ The patient has recurrent respiratory papillomatosis
- and
- ☐ The treatment is for intra-lesional administration

**Renewal — Recurrent Respiratory Papillomatosis**

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

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

**Prerequisites**(tick boxes where appropriate)

- ☐ Maximum of 6 doses
- and
- ☐ The treatment is for intra-lesional administration
- and
- ☐ There has been a reduction in surgical treatments or disease regrowth as a result of treatment

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Signed: ..... Date: .....

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| Fax Number: .....                              | .....                     | Fax Number: .....             |

**Bevacizumab** - *continued*

**Initial application — Ocular Conditions**

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

**Prerequisites**(tick boxes where appropriate)

- ☐ Ocular neovascularisation
- or
- ☐ Exudative ocular angiopathy

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: ..... Date: .....

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