

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:

Inotuzumab ozogamicin

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)

- ☐ Patient has relapsed or refractory CD22-positive B-cell acute lymphoblastic leukaemia/lymphoma, including minimal residual disease
- and
- ☐ Patient has ECOG performance status of 0-2
- and
- ☐ Patient has Philadelphia chromosome positive B-Cell ALL

and

☐ Patient has previously received a tyrosine kinase inhibitor
- or
- ☐ Patient has received one prior line of treatment involving intensive chemotherapy
- and
- ☐ Treatment is to be administered for a maximum of 3 cycles

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 4 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient is not proceeding to a stem cell transplant
- and
- ☐ Patient has experienced complete disease response

or

☐ Patient has experienced complete remission with incomplete haematological recovery
- and
- ☐ Treatment with inotuzumab ozogamicin is to cease after a total duration of 6 cycles

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