

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:

Filgrastim

Initial application

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

Prerequisites(tick boxes where appropriate)

- ☐ Prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 20%*)

or

☐ Peripheral blood stem cell mobilisation in patients undergoing haematological transplantation

or

☐ Peripheral blood stem cell mobilisation or bone marrow donation from healthy donors for transplantation

or

☐ Treatment of severe chronic neutropenia ($ANC < 0.5 \times 10^9/L$)

or

☐ Treatment of drug-induced prolonged neutropenia ($ANC < 0.5 \times 10^9/L$)

Note: *Febrile neutropenia risk greater than or equal to 20% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines.

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