

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:

Ruxolitinib

Initial application
Applications only from a haematologist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

The patient has primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis
and

A classification of risk of intermediate-2 or high-risk myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS
or

A classification of risk of intermediate-1 myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS
and
 Patient has severe disease-related symptoms that are resistant, refractory or intolerant to available therapy

and
 A maximum dose of 20 mg twice daily is to be given

Renewal
Current approval Number (if known):.....
Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment
and
 A maximum dose of 20 mg twice daily is to be given

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