

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:

Nilotinib

Initial application

Applications only from a haematologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis, high risk chronic phase, or in chronic phase
and	
<input type="checkbox"/>	Patient has documented CML treatment failure* with a tyrosine kinase inhibitor (TKI)
or	
<input type="checkbox"/>	Patient has experienced treatment limiting toxicity with a tyrosine kinase inhibitor (TKI) precluding further treatment
and	
<input type="checkbox"/>	Maximum nilotinib dose of 800 mg/day
and	
<input type="checkbox"/>	Subsidised for use as monotherapy only

Note: *treatment failure as defined by Leukaemia Net Guidelines.

Renewal

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

Applications only from a haematologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Lack of treatment failure while on nilotinib as defined by Leukaemia Net Guidelines
and	
<input type="checkbox"/>	Nilotinib treatment remains appropriate and the patient is benefiting from treatment
and	
<input type="checkbox"/>	Maximum nilotinib dose of 800 mg/day
and	
<input type="checkbox"/>	Subsidised for use as monotherapy only

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