

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:

Midostaurin

Initial application

Applications from any relevant practitioner. Approvals valid for 9 months.

Prerequisites(tick boxes where appropriate)

- Patient has a diagnosis of acute myeloid leukaemia
- and** Condition must be FMS tyrosine kinase 3 (FLT3) mutation positive
- and** Patient must not have received a prior line of intensive chemotherapy for acute myeloid leukaemia
- and** Patient is to receive standard intensive chemotherapy in combination with midostaurin only
- and** Midostaurin to be funded for a maximum of 4 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