

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:

Palbociclib (Ibrance)

Initial application

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- Patient has unresectable locally advanced or metastatic breast cancer
- and
- There is documentation confirming disease is hormone-receptor positive and HER2-negative
- and
- Patient has an ECOG performance score of 0-2

- or
- Disease has relapsed or progressed during prior endocrine therapy
- and
- Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state
- and
- Patient has not received prior systemic treatment for metastatic disease

- and
- Treatment must be used in combination with an endocrine partner
- and
- Patient has not received prior funded treatment with a CDK4/6 inhibitor

- or
- Patient has an active Special Authority approval for ribociclib
- and
- Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation
- and
- Treatment must be used in combination with an endocrine partner
- and
- There is no evidence of progressive disease since initiation of ribociclib

Renewal

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- Treatment must be used in combination with an endocrine partner
- and
- There is no evidence of progressive disease since initiation of palbociclib

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