

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:

Durvalumab

Initial application — Non-small cell lung cancer
Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

Patient has histologically or cytologically documented stage III, locally advanced, unresectable non-small cell lung cancer (NSCLC)

or

Patient has histologically or cytologically documented stage IIb (T1N2a only), locally advanced, unresectable non-small cell lung cancer (NSCLC)

and Patient has received two or more cycles of platinum-based chemotherapy concurrently with definitive radiation therapy

and Patient has no disease progression following the second or subsequent cycle of platinum-based chemotherapy with definitive radiation therapy treatment

and Patient has a ECOG performance status of 0 or 1

and Patient has completed last radiation dose within 8 weeks of starting treatment with durvalumab

and Patient must not have received prior PD-1 or PD-L1 inhibitor therapy for this condition

and

Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks

or

Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks

and Treatment with durvalumab to cease upon signs of disease progression

Renewal — Non-small cell lung cancer
Current approval Number (if known):.....
Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

The treatment remains clinically appropriate and the patient is benefitting from treatment

and

Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks

or

Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks

and Treatment with durvalumab to cease upon signs of disease progression

and Total continuous treatment duration must not exceed 12 months

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