

**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: .....

**Sunitinib**

**Initial application — RCC**  
Applications from any relevant practitioner. Approvals valid for 4 months.  
**Prerequisites**(tick boxes where appropriate)

The patient has metastatic renal cell carcinoma  
**and**  
 The patient has not previously received funded sunitinib

**Initial application — GIST**  
Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 3 months.  
**Prerequisites**(tick boxes where appropriate)

The patient has unresectable or metastatic malignant gastrointestinal stromal tumour (GIST)  
**and**  
 The patient's disease has progressed following treatment with imatinib  
**or**  
 The patient has documented treatment-limiting intolerance, or toxicity to, imatinib

**Renewal — RCC**  
Current approval Number (if known):.....  
Applications from any relevant practitioner. Approvals valid for 4 months.  
**Prerequisites**(tick box where appropriate)

There is no evidence of disease progression

**Renewal — GIST**  
Current approval Number (if known):.....  
Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.  
**Prerequisites**(tick boxes where appropriate)

**The patient has responded to treatment or has stable disease as determined by Choi's modified CT response evaluation criteria as follows:**

The patient has had a complete response (disappearance of all lesions and no new lesions)  
**or**  
 The patient has had a partial response (a decrease in size of 10% or more or decrease in tumour density in Hounsfield Units (HU) of 15% or more on CT and no new lesions and no obvious progression of non measurable disease)  
**or**  
 The patient has stable disease (does not meet criteria the two above) and does not have progressive disease and no symptomatic deterioration attributed to tumour progression

**and**  
 The treatment remains appropriate and the patient is benefiting from treatment

Note: It is recommended that response to treatment be assessed using Choi's modified CT response evaluation criteria (J Clin Oncol, 2007, 25:1753-1759). Progressive disease is defined as either: an increase in tumour size of 10% or more and not meeting criteria of partial response (PR) by tumour density (HU) on CT; or: new lesions, or new intratumoral nodules, or increase in the size of the existing intratumoral nodules.

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](mailto:customerservice@health.govt.nz)

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Sunitinib** - *continued*

**Renewal — GIST pandemic circumstances**

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

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	The patient has unresectable or metastatic malignant gastrointestinal stromal (GIST)
<b>and</b>	<input type="checkbox"/>
<input type="checkbox"/>	The patient is clinically benefiting from treatment and continued treatment remains appropriate
<b>and</b>	<input type="checkbox"/>
<input type="checkbox"/>	Sunitinib is to be discontinued at progression
<b>and</b>	<input type="checkbox"/>
<input type="checkbox"/>	The regular Special Authority renewal requirements cannot be met due to COVID-19 constraints on the health sector

**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](mailto:customerservice@health.govt.nz)