

<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: .....

**Azacitidine**

**Initial application**

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> The individual has intermediate or high risk MDS based on an internationally recognised scoring system <b>or</b> <input type="checkbox"/> The individual has chronic myelomonocytic leukaemia (based on an intermediate or high risk score from an internationally recognised scoring system or 10%-29% marrow blasts without myeloproliferative disorder) <b>or</b> <input type="checkbox"/> The individual has acute myeloid leukaemia according to World Health Organisation Classification (WHO)
<b>and</b> <input type="checkbox"/> The individual has an estimated life expectancy of at least 3 months

**Renewal**

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

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

**Prerequisites**(tick box where appropriate)

There is no evidence of disease progression

**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)