

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:

Ibrutinib

Initial application — chronic lymphocytic leukaemia (CLL)

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

Prerequisites(tick boxes where appropriate)

- ☐ Individual has chronic lymphocytic leukaemia (CLL) requiring therapy
- and
- ☐ Individual has not previously received funded ibrutinib
- and
- ☐ Ibrutinib is to be used as monotherapy
- and
- ☐ There is documentation confirming that the individual has 17p deletion or TP53 mutation

and

☐ Individual has experienced intolerable side effects with venetoclax monotherapy
- or
- ☐ Individual has received at least one prior immunochemotherapy for CLL

and

☐ Individual's CLL has relapsed

and

☐ Individual has experienced intolerable side effects with venetoclax in combination with rituximab regimen
- or
- ☐ Individual's CLL is refractory to or has relapsed following a venetoclax regimen

Renewal — chronic lymphocytic leukaemia (CLL)

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

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)*. Indications marked with * are Unapproved indications.

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