

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:

Bortezomib

Initial application — plasma cell dyscrasia
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick box where appropriate)

The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

Initial application — Waldenström Macroglobulinaemia
Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

The patient has Waldenström Macroglobulinaemia/Lymphoplasmacytic Lymphoma requiring treatment
and
 The patient has not received prior bortezomib treatment

Renewal — Waldenström Macroglobulinaemia
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 clinical disease progression during bortezomib use

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