

**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: .....

**Pazopanib**

**Initial application**

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 patient has metastatic renal cell carcinoma of predominantly clear cell histology

**and**

The patient is treatment naive

**or**

The patient has only received prior cytokine treatment

**and**

The patient has an ECOG performance score of 0-2

**and**

**The patient has intermediate or poor prognosis defined as:**

Lactate dehydrogenase level > 1.5 times upper limit of normal

**or**

Haemoglobin level < lower limit of normal

**or**

Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)

**or**

Interval of < 1 year from original diagnosis to the start of systemic therapy

**or**

Karnofsky performance score of less than or equal to 70

**or**

2 or more sites of organ metastasis

**and**

Pazopanib to be used for a maximum of 3 months

**or**

The patient has metastatic renal cell carcinoma

**and**

The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance

**and**

The cancer did not progress whilst on sunitinib

**and**

Pazopanib to be used for a maximum of 3 months

**Renewal**

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 3 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)