

<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: .....

**Deferasirox**

**Initial application**

Applications only from a haematologist. Approvals valid for 2 years.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	The patient has been diagnosed with chronic iron overload due to congenital inherited anaemia
<b>and</b>	
<input type="checkbox"/>	Deferasirox is to be given at a daily dose not exceeding 40 mg/kg/day
<b>and</b>	
<input type="checkbox"/>	Treatment with maximum tolerated doses of deferiprone monotherapy or deferiprone and desferrioxamine combination therapy have proven ineffective as measured by serum ferritin levels, liver or cardiac MRI T2*
<b>or</b>	
<input type="checkbox"/>	Treatment with deferiprone has resulted in severe persistent vomiting or diarrhoea
<b>or</b>	
<input type="checkbox"/>	Treatment with deferiprone has resulted in arthritis
<b>or</b>	
<input type="checkbox"/>	Treatment with deferiprone is contraindicated due to a history of agranulocytosis (defined as an absolute neutrophil count (ANC) of < 0.5 cells per µL) or recurrent episodes (greater than 2 episodes) of moderate neutropenia (ANC 0.5 - 1.0 cells per µL)

**Renewal**

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

Applications only from a haematologist. Approvals valid for 2 years.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	For the first renewal following 2 years of therapy, the treatment has been tolerated and has resulted in clinical improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels
<b>or</b>	
<input type="checkbox"/>	For subsequent renewals, the treatment has been tolerated and has resulted in clinical stability or continued improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels

**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)