

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER** Reg No: .....

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

.....      Address: .....      .....

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Fax Number: .....      Fax Number: .....

**Cinacalct**

**Initial application — parathyroid carcinoma or calciphylaxis**

Applications only from a nephrologist or endocrinologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- The patient has been diagnosed with a parathyroid carcinoma (see Note)
- and
- The patient has persistent hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) despite previous first-line treatments including sodium thiosulfate (where appropriate) and bisphosphonates
- and
- The patient is symptomatic

- or
- The patient has been diagnosed with calciphylaxis (calcific uraemic arteriopathy)
  - and
  - The patient has symptomatic (e.g. painful skin ulcers) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L)
  - and
  - The patient's condition has not responded to previous first-line treatments including bisphosphonates and sodium thiosulfate

**Renewal — parathyroid carcinoma or calciphylaxis**

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

Applications only from a nephrologist or endocrinologist. Approvals valid without further renewal unless notified.

**Prerequisites**(tick boxes where appropriate)

- The patient's serum calcium level has fallen to < 3mmol/L
- and
- The patient has experienced clinically significant symptom improvement

Note: This does not include parathyroid adenomas unless these have become malignant.

**Initial application — primary hyperparathyroidism**

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

**Prerequisites**(tick boxes where appropriate)

- Patient has primary hyperparathyroidism
- and
- Patient has hypercalcaemia of more than 3 mmol/L with or without symptoms
- or
- Patient has hypercalcaemia of more than 2.85 mmol/L with symptoms
- and
- Surgery is not feasible or has failed
- and
- Patient has other comorbidities, severe bone pain, or calciphylaxis

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)

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|------------------------------------------------|---------------------------|-------------------------------|
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| Reg No: .....                                  | First Names: .....        | First Names: .....            |
| Name: .....                                    | Surname: .....            | Surname: .....                |
| Address: .....                                 | DOB: .....                | Address: .....                |
| .....                                          | Address: .....            | .....                         |
| .....                                          | .....                     | .....                         |
| Fax Number: .....                              | .....                     | Fax Number: .....             |

**Cinacalcet** - *continued*

**Initial application — secondary or tertiary hyperparathyroidism**

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

**Prerequisites**(tick boxes where appropriate)

Patient has tertiary hyperparathyroidism and markedly elevated parathyroid hormone (PTH) with hypercalcaemia

or

Patient has symptomatic secondary hyperparathyroidism and elevated PTH

and

Patient is on renal replacement therapy

and

Residual parathyroid tissue has not been localised despite repeat unsuccessful parathyroid explorations

or

Parathyroid tissue is surgically inaccessible

or

Parathyroid surgery is not feasible

**Renewal — secondary or tertiary hyperparathyroidism**

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

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

**Prerequisites**(tick boxes where appropriate)

The patient has had a kidney transplant, and following a treatment free interval of at least 12 weeks a clinically acceptable parathyroid hormone (PTH) level to support ongoing cessation of treatment has not been reached

or

The patient has not received a kidney transplant and trial of withdrawal of cinacalcet is clinically inappropriate

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

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