

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

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

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

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

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

**Gemtuzumab ozogamicin**

**Initial application**

Applications only from a haematologist, paediatric haematologist or paediatric oncologist. Approvals valid for 3 months.

**Prerequisites**(tick boxes where appropriate)

- Patient has not received prior chemotherapy for this condition
- and  Patient has de novo CD33-positive acute myeloid leukaemia
- and  Patient does not have acute promyelocytic leukaemia
- and  Gemtuzumab ozogamicin will be used in combination with standard anthracycline and cytarabine (AraC)
- and  Patient is being treated with curative intent
- and  Patient's disease risk has been assessed by cytogenetic testing to be good or intermediate
- and  Patient must be considered eligible for standard intensive remission induction chemotherapy with standard anthracycline and cytarabine (AraC)
- and  Gemtuzumab ozogamicin to be funded for one course only (one dose at 3 mg per m<sup>2</sup> body surface area or up to 2 vials of 5 mg as separate doses)

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

**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)