

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:

Palbociclib (Ibrance)

Initial application

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

Prerequisites(tick boxes where appropriate)

Patient has unresectable locally advanced or metastatic breast cancer
and There is documentation confirming disease is hormone-receptor positive and HER2-negative
and Patient has an ECOG performance score of 0-2
and

Disease has relapsed or progressed during prior endocrine therapy
or

Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state
and Patient has not received prior systemic treatment for metastatic disease

and Treatment must be used in combination with an endocrine partner
and Patient has not received prior funded treatment with a CDK4/6 inhibitor

or

Patient has an active Special Authority approval for ribociclib
and Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation
and Treatment must be used in combination with an endocrine partner
and There is no evidence of progressive disease since initiation of ribociclib

Renewal

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

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

Prerequisites(tick boxes where appropriate)

Treatment must be used in combination with an endocrine partner
and There is no evidence of progressive disease since initiation of palbociclib

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