

<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: .....

**Thalidomide**

**Initial application**

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

**Prerequisites**(tick box where appropriate)

The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

**Renewal**

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

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

**Prerequisites**(tick box where appropriate)

The patient has obtained a response from treatment during the initial approval period

Note: Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier.  
Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen.

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)