

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:

Dasatinib

Initial application

Applications only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	The patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis or accelerated phase
or	
<input type="checkbox"/>	The patient has a diagnosis of Philadelphia chromosome-positive acute lymphoid leukaemia (Ph+ ALL)
or	
<input type="checkbox"/>	The patient has a diagnosis of CML in chronic phase
and	
<input type="checkbox"/>	Patient has documented treatment failure* with imatinib
or	
<input type="checkbox"/>	Patient has experienced treatment-limiting toxicity with imatinib precluding further treatment with imatinib
or	
<input type="checkbox"/>	Patient has high-risk chronic-phase CML defined by the Sokal or EURO scoring system

Renewal

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

Applications only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Lack of treatment failure while on dasatinib*
and	
<input type="checkbox"/>	Dasatinib treatment remains appropriate and the patient is benefiting from treatment

Note: *treatment failure for CML as defined by Leukaemia Net Guidelines.

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