

**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: .....

**Ribociclib**

**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 endocrine treatment for metastatic disease

**and**  Treatment to 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 palbociclib

**and**  Patient has experienced a grade 3 or 4 adverse reaction to palbociclib 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 palbociclib

**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 ribociclib

**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)