

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:

Everolimus

Initial application
Applications only from a neurologist or oncologist. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

Patient has tuberous sclerosis
and
 Patient has progressively enlarging sub-ependymal giant cell astrocytomas (SEGAs) that require treatment

Renewal
Current approval Number (if known):.....
Applications only from a neurologist or oncologist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months
and
 The treatment remains appropriate and the patient is benefiting from treatment
and
 Everolimus to be discontinued at progression of SEGAs

Initial application — renal cell carcinoma
Applications from any relevant practitioner. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

The patient has metastatic renal cell carcinoma
and
 The disease is of predominant clear-cell histology
and
 The patient has documented disease progression following one previous line of treatment
and
 The patient has an ECOG performance status of 0-2
and
 Everolimus is to be used in combination with lenvatinib

or

Patient has received funded treatment with nivolumab for the second line treatment of metastatic renal cell carcinoma
and
 Patient has experienced treatment limiting toxicity from treatment with nivolumab
and
 Everolimus is to be used in combination with lenvatinib
and
 There is no evidence of disease progression

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

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Everolimus - *continued*

Renewal — renal cell carcinoma

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

Applications from any relevant practitioner. Approvals valid for 4 months.

Prerequisites(tick box where appropriate)

There is no evidence of disease progression

I confirm the above details are correct and that in signing this form I understand I may be audited.

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