

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:

Pegylated Interferon alfa-2A

Initial application — chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant

Applications from any specialist. Approvals valid for 18 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection or <input type="checkbox"/> Patient has chronic hepatitis C and is co-infected with HIV or <input type="checkbox"/> Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant and <input type="checkbox"/> Maximum of 48 weeks therapy

Renewal — Chronic hepatitis C - genotype 1 infection

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

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Patient has chronic hepatitis C, genotype 1 and <input type="checkbox"/> Patient has had previous treatment with pegylated interferon and ribavirin and <input type="checkbox"/> Patient has responder relapsed or <input type="checkbox"/> Patient was a partial responder and <input type="checkbox"/> Patient is to be treated in combination with boceprevir and <input type="checkbox"/> Maximum of 48 weeks therapy

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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Pegylated Interferon alfa-2A - *continued*

Initial application — Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.

Prerequisites(tick boxes where appropriate)

Patient has chronic hepatitis C, genotype 1

and Patient has had previous treatment with pegylated interferon and ribavirin

and

Patient has responder relapsed

or Patient was a partial responder

or Patient received interferon treatment prior to 2004

and Patient is to be treated in combination with boceprevir

and Maximum of 48 weeks therapy

Initial application — chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV

Applications from any specialist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

Patient has chronic hepatitis C, genotype 2 or 3 infection

and Maximum of 6 months therapy

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

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Pegylated Interferon alfa-2A - *continued*

Initial application — Hepatitis B

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.

Prerequisites(tick boxes where appropriate)

Patient has confirmed Hepatitis B infection (HBsAg positive for more than 6 months)

and Patient is Hepatitis B treatment-naive

and ALT > 2 times Upper Limit of Normal

and HBV DNA < 10 log10 IU/ml

and

HBeAg positive

or

Serum HBV DNA greater than or equal to 2,000 units/ml and significant fibrosis (Metavir Stage F2 or greater or moderate fibrosis)

and Compensated liver disease

and No continuing alcohol abuse or intravenous drug use

and Not co-infected with HCV, HIV or HDV

and Neither ALT nor AST > 10 times upper limit of normal

and No history of hypersensitivity or contraindications to pegylated interferon

and Maximum of 48 weeks therapy

Initial application — myeloproliferative disorder or cutaneous T cell lymphoma

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

Prerequisites(tick boxes where appropriate)

Patient has a cutaneous T cell lymphoma*

or

Patient has a myeloproliferative disorder*

and Patient is intolerant of hydroxyurea

and Treatment with anagrelide and busulfan is not clinically appropriate

or

Patient has a myeloproliferative disorder

and Patient is pregnant, planning pregnancy or lactating

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Pegylated Interferon alfa-2A - *continued*

Renewal — myeloproliferative disorder or cutaneous T cell lymphoma

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

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

Prerequisites(tick boxes where appropriate)

No evidence of disease progression

and The treatment remains appropriate and patient is benefitting from treatment

and

Patient has a cutaneous T cell lymphoma*

or

Patient has a myeloproliferative disorder*

and

Remains intolerant of hydroxyurea and treatment with anagrelide and busulfan remains clinically inappropriate

or

Patient is pregnant, planning pregnancy or lactating

Note: Indications marked with * are unapproved indications.

Initial application — post-allogenic bone marrow transplant

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick box where appropriate)

Patient has received an allogenic bone marrow transplant* and has evidence of disease relapse

Renewal — post-allogenic bone marrow transplant

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

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick box where appropriate)

Patient is responding and ongoing treatment remains appropriate

Note: Indications marked with * are unapproved indications.

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

Signed: Date:

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