

<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: .....	.....
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Fax Number: .....	.....	Fax Number: .....

**Lenalidomide**

**Initial application — Plasma cell dyscrasia**

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> Patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment <b>and</b> <input type="checkbox"/> Patient is not refractory to prior lenalidomide use
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**Initial application — Myelodysplastic syndrome**

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> Patient has low or intermediate-1 risk myelodysplastic syndrome (based on IPSS or an IPSS-R score of less than 3.5) associated with a deletion 5q cytogenetic abnormality <b>and</b> <input type="checkbox"/> Patient has transfusion-dependent anaemia
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**Renewal — Myelodysplastic syndrome**

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

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> Patient has not needed a transfusion in the last 4 months <b>and</b> <input type="checkbox"/> No evidence of disease progression
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**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)