

**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: .....

**Durvalumab**

**Initial application — Non-small cell lung cancer**

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months.

**Prerequisites**(tick boxes where appropriate)

Patient has histologically or cytologically documented stage III, locally advanced, unresectable non-small cell lung cancer (NSCLC)

or

Patient has histologically or cytologically documented stage IIb (T1N2a only), locally advanced, unresectable non-small cell lung cancer (NSCLC)

and  Patient has received two or more cycles of platinum-based chemotherapy concurrently with definitive radiation therapy

and  Patient has no disease progression following the second or subsequent cycle of platinum-based chemotherapy with definitive radiation therapy treatment

and  Patient has a ECOG performance status of 0 or 1

and  Patient has completed last radiation dose within 8 weeks of starting treatment with durvalumab

and  Patient must not have received prior PD-1 or PD-L1 inhibitor therapy for this condition

and  Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks

or

Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks

and  Treatment with durvalumab to cease upon signs of disease progression

**Renewal — Non-small cell lung cancer**

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

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months.

**Prerequisites**(tick boxes where appropriate)

The treatment remains clinically appropriate and the patient is benefitting from treatment

and  Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks

or

Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks

and  Treatment with durvalumab to cease upon signs of disease progression

and  Total continuous treatment duration must not exceed 12 months

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)