

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

**Temozolomide**

**Initial application — gliomas**

Applications only from a relevant specialist. Approvals valid for 12 months.

**Prerequisites**(tick box where appropriate)

The patient has a glioma

**Renewal — gliomas**

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

Applications only from a relevant specialist. Approvals valid for 12 months.

**Prerequisites**(tick box where appropriate)

Treatment remains appropriate and patient is benefitting from treatment

**Initial application — neuroendocrine tumours**

Applications only from a relevant specialist. Approvals valid for 9 months.

**Prerequisites**(tick boxes where appropriate)

- Patient has been diagnosed with metastatic or unresectable well-differentiated neuroendocrine tumour\*
- and**
- Temozolomide is to be given in combination with capecitabine
- and**
- Temozolomide is to be used in 28 day treatment cycles for a maximum of 5 days treatment per cycle at a maximum dose of 200 mg/m<sup>2</sup> per day
- and**
- Temozolomide to be discontinued at disease progression

**Renewal — neuroendocrine tumours**

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

Applications only from a relevant specialist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- No evidence of disease progression
- and**
- The treatment remains appropriate and the patient is benefitting from treatment

**Initial application — ewing's sarcoma**

Applications only from a relevant specialist. Approvals valid for 9 months.

**Prerequisites**(tick box where appropriate)

The patient has relapsed/refractory Ewing's sarcoma

**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)

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.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Temozolomide** - *continued*

**Renewal — ewing’s sarcoma**

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

Applications only from a relevant specialist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> No evidence of disease progression <b>and</b> <input type="checkbox"/> The treatment remains appropriate and the patient is benefitting from treatment
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**Initial application — Neuroblastoma**

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

**Prerequisites**(tick box where appropriate)

The patient has neuroblastoma

**Renewal — Neuroblastoma**

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

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

**Prerequisites**(tick box where appropriate)

There is no evidence of disease progression

Note: Indication marked with a \* is an unapproved indication. Temozolomide is not subsidised for the treatment of relapsed high grade glioma.

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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