

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:

Nilotinib

Initial application

Applications only from a haematologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

Patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis, high risk chronic phase, or in chronic phase

and

Patient has documented CML treatment failure* with a tyrosine kinase inhibitor (TKI)

or

Patient has experienced treatment limiting toxicity with a tyrosine kinase inhibitor (TKI) precluding further treatment

and

Maximum nilotinib dose of 800 mg/day

and

Subsidised for use as monotherapy only

Note: *treatment failure as defined by Leukaemia Net Guidelines.

Renewal

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

Applications only from a haematologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

Lack of treatment failure while on nilotinib as defined by Leukaemia Net Guidelines

and

Nilotinib treatment remains appropriate and the patient is benefiting from treatment

and

Maximum nilotinib dose of 800 mg/day

and

Subsidised for use as monotherapy only

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