

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:

Filgrastim

Initial application

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

Prerequisites(tick boxes where appropriate)

- Prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 20%*)
- or
- Peripheral blood stem cell mobilisation in patients undergoing haematological transplantation
- or
- Peripheral blood stem cell mobilisation or bone marrow donation from healthy donors for transplantation
- or
- Treatment of severe chronic neutropenia (ANC < 0.5 ×10⁹/L)
- or
- Treatment of drug-induced prolonged neutropenia (ANC < 0.5 ×10⁹/L)

Note: *Febrile neutropenia risk greater than or equal to 20% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines.

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