

|  |                           |                               |
|--|---------------------------|-------------------------------|
| <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: .....             |

**Venetoclax**

**Initial application — previously untreated chronic lymphocytic leukaemia in combination with obinutuzumab**  
Applications from any relevant practitioner. Approvals valid for 15 months.  
**Prerequisites**(tick boxes where appropriate)

Individual is currently on treatment with venetoclax and obinutuzumab and met all of the following criteria prior to commencing treatment

or

Individual has previously untreated chronic lymphocytic leukaemia  
and  
 Venetoclax is to be administered with obinutuzumab  
and  
 Venetoclax is to be used to a maximum dose of 400 mg and for a total of 12 (28 day) cycles

**Initial application — previously untreated chronic lymphocytic leukaemia in combination with ibrutinib**  
Applications from any relevant practitioner. Approvals valid for 15 months.  
**Prerequisites**(tick boxes where appropriate)

Individual is currently on treatment with venetoclax and/or ibrutinib and met all of the following criteria prior to commencing treatment

or

Individual has previously untreated chronic lymphocytic leukaemia  
and  
 Venetoclax is to be administered in combination with ibrutinib  
and  
 Venetoclax is to be used to a maximum dose of 400 mg and for a total of 12 (28 day) cycles

**Initial application — relapsed/refractory chronic lymphocytic leukaemia**  
Applications from any relevant practitioner. Approvals valid for 8 months.  
**Prerequisites**(tick boxes where appropriate)

Individual has chronic lymphocytic leukaemia requiring treatment  
and  
 Individual has received at least one prior therapy for chronic lymphocytic leukaemia  
and  
 The individual's disease has relapsed  
and  
 Venetoclax to be used in combination with six 28-day cycles of rituximab commencing after the 5-week dose titration schedule with venetoclax  
and  
 Individual has an ECOG performance status of 0-2

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)

**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: .....

**Venetoclax - continued**

**Renewal — relapsed/refractory chronic lymphocytic leukaemia**

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

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

**Prerequisites**(tick boxes where appropriate)

- Treatment remains clinically appropriate and the individual is benefitting from and tolerating treatment
- and**
- Venetoclax is to be discontinued after a maximum of 24 months of treatment following the titration schedule unless earlier discontinuation is required due to disease progression or unacceptable toxicity

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell polymorphocytic leukaemia (B-PLL)\*. Indications marked with \* are Unapproved indications.

**Initial application — previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation\***

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

**Prerequisites**(tick boxes where appropriate)

- Individual has previously untreated chronic lymphocytic leukaemia
- and**
- There is documentation confirming that individual has 17p deletion by FISH testing or TP53 mutation by sequencing
- and**
- Individual has an ECOG performance status of 0-2

**Renewal — previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation\***

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

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

**Prerequisites**(tick box where appropriate)

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

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL)\* and B-cell polymorphocytic leukaemia (B-PLL)\*. Indications marked with \* are Unapproved indications

**Initial application — previously untreated acute myeloid leukaemia**

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

**Prerequisites**(tick boxes where appropriate)

- The individual is currently on treatment with venetoclax and met all remaining special authority criteria prior to commencing treatment
- or**
- Individual has previously untreated acute myeloid leukaemia (see note a), according to World Health Organization (WHO) Classification
- and**
- Venetoclax not to be used in combination with standard intensive remission induction chemotherapy
- and**
- Venetoclax to be used in combination with azacitidine or low dose cytarabine

**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)

|  |                           |                               |
|--|---------------------------|-------------------------------|
| <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: .....             |

**Venetoclax** - *continued*

**Renewal — previously untreated acute myeloid leukaemia**

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

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

**Prerequisites**(tick box where appropriate)

There is no evidence of disease progression

Note:

- a) 'Acute myeloid leukaemia' includes myeloid sarcoma\*
- b) Indications marked with \* are Unapproved indications

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)