

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:

Deferasirox

Initial application

Applications only from a haematologist. Approvals valid for 2 years.

Prerequisites(tick boxes where appropriate)

- ☐ The patient has been diagnosed with chronic iron overload due to congenital inherited anaemia
- and
- ☐ Deferasirox is to be given at a daily dose not exceeding 40 mg/kg/day
- and
- ☐ Treatment with maximum tolerated doses of deferiprone monotherapy or deferiprone and desferrioxamine combination therapy have proven ineffective as measured by serum ferritin levels, liver or cardiac MRI T2*

or

☐ Treatment with deferiprone has resulted in severe persistent vomiting or diarrhoea

or

☐ Treatment with deferiprone has resulted in arthritis

or

☐ Treatment with deferiprone is contraindicated due to a history of agranulocytosis (defined as an absolute neutrophil count (ANC) of < 0.5 cells per μ L) or recurrent episodes (greater than 2 episodes) of moderate neutropenia (ANC 0.5 - 1.0 cells per μ L)

Renewal

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

Applications only from a haematologist. Approvals valid for 2 years.

Prerequisites(tick boxes where appropriate)

- ☐ For the first renewal following 2 years of therapy, the treatment has been tolerated and has resulted in clinical improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels
- or
- ☐ For subsequent renewals, the treatment has been tolerated and has resulted in clinical stability or continued improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels

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