

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:

Ruxolitinib

Initial application

Applications only from a haematologist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- ☐ The patient has primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis
- and
- ☐ A classification of risk of intermediate-2 or high-risk myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS
- or
- ☐ A classification of risk of intermediate-1 myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS

and

☐ Patient has severe disease-related symptoms that are resistant, refractory or intolerant to available therapy
- and
- ☐ A maximum dose of 20 mg twice daily is to be given

Renewal

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

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment
- and
- ☐ A maximum dose of 20 mg twice daily is to be given

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