

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:

Midostaurin

Initial application
Applications from any relevant practitioner. Approvals valid for 9 months.

Prerequisites(tick boxes where appropriate)

☐ Patient has a diagnosis of acute myeloid leukaemia

and

☐ Condition must be FMS tyrosine kinase 3 (FLT3) mutation positive

and

☐ Patient must not have received a prior line of intensive chemotherapy for acute myeloid leukaemia

and

☐ Patient is to receive standard intensive chemotherapy in combination with midostaurin only

and

☐ Midostaurin to be funded for a maximum of 4 cycles

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