

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:

Pegaspargase

Initial application — Acute lymphoblastic leukaemia

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 15 months.

Prerequisites(tick boxes where appropriate)

- ☐ The patient has newly diagnosed acute lymphoblastic leukaemia
- and
- ☐ Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol

Initial application — Lymphoma

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

Prerequisites(tick box where appropriate)

- ☐ The patient has lymphoma requiring L-asparaginase containing protocols (e.g. SMILE)

Renewal — Acute lymphoblastic leukaemia

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 patient has relapsed acute lymphoblastic leukaemia
- and
- ☐ Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol

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