

|                                                |                           |                               |
|------------------------------------------------|---------------------------|-------------------------------|
| <b>APPLICANT</b> (stamp or sticker acceptable) | <b>PATIENT</b> NHI: ..... | <b>REFERRER</b> Reg No: ..... |
| Reg No: .....                                  | First Names: .....        | First Names: .....            |
| Name: .....                                    | Surname: .....            | Surname: .....                |
| Address: .....                                 | DOB: .....                | Address: .....                |
| .....                                          | Address: .....            | .....                         |
| .....                                          | .....                     | .....                         |
| Fax Number: .....                              | .....                     | Fax Number: .....             |

## Ibrutinib

### Initial application — previously untreated chronic lymphocytic leukaemia in combination with venetoclax

Applications from any relevant practitioner. Approvals valid for 15 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Individual is currently on treatment with ibrutinib and/or venetoclax and met all of the following criteria prior to commencing treatment
- or
- ☐ Individual has previously untreated CLL

and

☐ Ibrutinib is to be administered at a maximum dose of 420 mg daily for 3 (28 day) cycles as monotherapy, followed by a maximum of 12 (28 day) cycles in combination with venetoclax

### Initial application — chronic lymphocytic leukaemia (CLL)

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

**Prerequisites**(tick boxes where appropriate)

- ☐ Individual has chronic lymphocytic leukaemia (CLL) requiring therapy
- and
- ☐ Ibrutinib is to be used as monotherapy
- and
- ☐ Individual has experienced intolerable side effects, or their disease has relapsed or is refractory following at least one prior line of therapy
- and
- ☐ Individual has not received ibrutinib monotherapy previously

### Renewal — chronic lymphocytic leukaemia (CLL)

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

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick box where appropriate)

- ☐ There is no evidence of disease progression

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)\*. 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)