

|                                                |                           |                               |
|------------------------------------------------|---------------------------|-------------------------------|
| <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: .....            | .....                         |
| .....                                          | .....                     | .....                         |
| .....                                          | .....                     | .....                         |

### Pegylated Interferon alfa-2A

#### Initial application — chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant

Applications from any specialist. Approvals valid for 18 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection
- or
- ☐ Patient has chronic hepatitis C and is co-infected with HIV
- or
- ☐ Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant

and

- ☐ Maximum of 48 weeks therapy

#### Renewal — Chronic hepatitis C - genotype 1 infection

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

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 1
- and
- ☐ Patient has had previous treatment with pegylated interferon and ribavirin
- and
- ☐ Patient has responder relapsed
- or
- ☐ Patient was a partial responder

and

- ☐ Patient is to be treated in combination with boceprevir

and

- ☐ Maximum of 48 weeks therapy

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)

|                                                |                           |                               |
|------------------------------------------------|---------------------------|-------------------------------|
| <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: .....            | .....                         |
| .....                                          | .....                     | .....                         |
| .....                                          | .....                     | .....                         |

**Pegylated Interferon alfa-2A** - *continued*

**Initial application — Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior**

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 1
- and
- ☐ Patient has had previous treatment with pegylated interferon and ribavirin
- and
- ☐ Patient has responder relapsed

or

☐ Patient was a partial responder

or

☐ Patient received interferon treatment prior to 2004
- and
- ☐ Patient is to be treated in combination with boceprevir
- and
- ☐ Maximum of 48 weeks therapy

**Initial application — chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV**

Applications from any specialist. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 2 or 3 infection
- and
- ☐ Maximum of 6 months therapy

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)

|                                                |                           |                               |
|------------------------------------------------|---------------------------|-------------------------------|
| <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: .....            | .....                         |
| .....                                          | .....                     | .....                         |
| .....                                          | .....                     | .....                         |

**Pegylated Interferon alfa-2A** - continued

**Initial application — Hepatitis B**

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has confirmed Hepatitis B infection (HBsAg positive for more than 6 months)
- and
- ☐ Patient is Hepatitis B treatment-naïve
- and
- ☐ ALT > 2 times Upper Limit of Normal
- and
- ☐ HBV DNA < 10 log10 IU/ml
- and
- ☐ HBeAg positive

or

☐ Serum HBV DNA greater than or equal to 2,000 units/ml and significant fibrosis (Metavir Stage F2 or greater or moderate fibrosis)
- and
- ☐ Compensated liver disease
- and
- ☐ No continuing alcohol abuse or intravenous drug use
- and
- ☐ Not co-infected with HCV, HIV or HDV
- and
- ☐ Neither ALT nor AST > 10 times upper limit of normal
- and
- ☐ No history of hypersensitivity or contraindications to pegylated interferon
- and
- ☐ Maximum of 48 weeks therapy

**Initial application — myeloproliferative disorder or cutaneous T cell lymphoma**

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

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has a cutaneous T cell lymphoma\*
- or
- ☐ Patient has a myeloproliferative disorder\*

and

☐ Patient is intolerant of hydroxyurea

and

☐ Treatment with anagrelide and busulfan is not clinically appropriate
- or
- ☐ Patient has a myeloproliferative disorder

and

☐ Patient is pregnant, planning pregnancy or lactating

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)

|                                                |                           |                               |
|------------------------------------------------|---------------------------|-------------------------------|
| <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: .....            | .....                         |
| .....                                          | .....                     | .....                         |
| .....                                          | .....                     | .....                         |

**Pegylated Interferon alfa-2A** - continued

**Renewal — myeloproliferative disorder or cutaneous T cell lymphoma**

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

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

**Prerequisites**(tick boxes where appropriate)

- ☐ No evidence of disease progression
- and
- ☐ The treatment remains appropriate and patient is benefitting from treatment
- and
- ☐ Patient has a cutaneous T cell lymphoma\*
- or
- ☐ Patient has a myeloproliferative disorder\*
- and
- ☐ Remains intolerant of hydroxyurea and treatment with anagrelide and busulfan remains clinically inappropriate
- or
- ☐ Patient is pregnant, planning pregnancy or lactating

Note: Indications marked with \* are unapproved indications.

**Initial application — post-allogeneic bone marrow transplant**

Applications from any relevant practitioner. Approvals valid for 3 months.

**Prerequisites**(tick box where appropriate)

- ☐ Patient has received an allogeneic bone marrow transplant\* and has evidence of disease relapse

**Renewal — post-allogeneic bone marrow transplant**

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

Applications from any relevant practitioner. Approvals valid for 3 months.

**Prerequisites**(tick box where appropriate)

- ☐ Patient is responding and ongoing treatment remains appropriate

Note: 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)