

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....	Address:	
.....		
.....		

Venetoclax

Initial application — previously untreated chronic lymphocytic leukaemia in combination with obinutuzumab

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

Prerequisites(tick boxes where appropriate)

- ☐ Individual is currently on treatment with venetoclax and obinutuzumab and met all of the following criteria prior to commencing treatment
- or
- ☐ Individual has previously untreated chronic lymphocytic leukaemia
- and
- ☐ Venetoclax is to be administered with obinutuzumab
- and
- ☐ Venetoclax is to be used to a maximum dose of 400 mg and for a total of 12 (28 day) cycles

Initial application — previously untreated chronic lymphocytic leukaemia in combination with ibrutinib

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

Prerequisites(tick boxes where appropriate)

- ☐ Individual is currently on treatment with venetoclax and/or ibrutinib and met all of the following criteria prior to commencing treatment
- or
- ☐ Individual has previously untreated chronic lymphocytic leukaemia
- and
- ☐ Venetoclax is to be administered in combination with ibrutinib
- and
- ☐ Venetoclax is to be used to a maximum dose of 400 mg and for a total of 12 (28 day) cycles

Initial application — relapsed/refractory chronic lymphocytic leukaemia

Applications from any relevant practitioner. Approvals valid for 8 months.

Prerequisites(tick boxes where appropriate)

- ☐ Individual has chronic lymphocytic leukaemia requiring treatment
- and
- ☐ Individual has received at least one prior therapy for chronic lymphocytic leukaemia
- and
- ☐ The individual's disease has relapsed
- and
- ☐ Venetoclax to be used in combination with six 28-day cycles of rituximab commencing after the 5-week dose titration schedule with venetoclax
- and
- ☐ Individual has an ECOG performance status of 0-2

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

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....	Address:	
.....		
.....		

Venetoclax - continued

Renewal — relapsed/refractory chronic lymphocytic leukaemia

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

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

Prerequisites(tick boxes where appropriate)

- ☐ Treatment remains clinically appropriate and the individual is benefitting from and tolerating treatment
- and
- ☐ Venetoclax is to be discontinued after a maximum of 24 months of treatment following the titration schedule unless earlier discontinuation is required due to disease progression or unacceptable toxicity

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)*. Indications marked with * are Unapproved indications.

Initial application — previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation*

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

Prerequisites(tick boxes where appropriate)

- ☐ Individual has previously untreated chronic lymphocytic leukaemia
- and
- ☐ There is documentation confirming that individual has 17p deletion by FISH testing or TP53 mutation by sequencing
- and
- ☐ Individual has an ECOG performance status of 0-2

Renewal — previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation*

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

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

Prerequisites(tick box where appropriate)

- ☐ The treatment remains clinically appropriate and the patient is benefitting from and tolerating treatment

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL)* and B-cell prolymphocytic leukaemia (B-PLL)*. Indications marked with * are Unapproved indications

Initial application — previously untreated acute myeloid leukaemia

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

Prerequisites(tick boxes where appropriate)

- ☐ The individual is currently on treatment with venetoclax and met all remaining special authority criteria prior to commencing treatment
- or
- ☐ Individual has previously untreated acute myeloid leukaemia (see note a), according to World Health Organization (WHO) Classification

and

☐ Venetoclax not to be used in combination with standard intensive remission induction chemotherapy

and

☐ Venetoclax to be used in combination with azacitidine or low dose cytarabine

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

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....	Address:	
.....		
.....		

Venetoclax - continued

Renewal — previously untreated acute myeloid leukaemia

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

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

Prerequisites(tick box where appropriate)

☐

There is no evidence of disease progression

Note:

a) 'Acute myeloid leukaemia' includes myeloid sarcoma*

b) 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