

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

Everolimus

Initial application

Applications only from a neurologist or oncologist. Approvals valid for 4 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has tuberous sclerosis
- and
- ☐ Patient has progressively enlarging sub-ependymal giant cell astrocytomas (SEGAs) that require treatment

Renewal

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

Applications only from a neurologist or oncologist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- ☐ Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months
- and
- ☐ The treatment remains appropriate and the patient is benefiting from treatment
- and
- ☐ Everolimus to be discontinued at progression of SEGAs

Initial application — renal cell carcinoma

Applications from any relevant practitioner. Approvals valid for 4 months.

Prerequisites(tick boxes where appropriate)

- ☐ The patient has metastatic renal cell carcinoma

and

☐ The disease is of predominant clear-cell histology

and

☐ The patient has documented disease progression following one previous line of treatment

and

☐ The patient has an ECOG performance status of 0-2

and

☐ Everolimus is to be used in combination with lenvatinib
- or
- ☐ Patient has received funded treatment with nivolumab for the second line treatment of metastatic renal cell carcinoma

and

☐ Patient has experienced treatment limiting toxicity from treatment with nivolumab

and

☐ Everolimus is to be used in combination with lenvatinib

and

☐ There is no evidence of disease progression

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

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Everolimus - *continued*

Renewal — renal cell carcinoma

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

Applications from any relevant practitioner. Approvals valid for 4 months.

Prerequisites(tick box where appropriate)

☐ There is no evidence of disease progression

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:
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