

APPLICATION FOR IMATINIB MESYLATE FOR TREATMENT OF GASTROINTESTINAL STROMAL TUMOUR (GIST)

Please send applications and prescriptions to:

The Imatinib Co-ordinator
PHARMAC
PO Box 10-254
WELLINGTON

Phone: 04 460 4990
Facsimile: 04 916 7571
Email: mary.chesterfield@
pharmac.govt.nz

Details of applying practitioner	Patient details
Specialty:..... <i>Application to be made, and subsequent prescriptions can be written, by an oncologist.</i> Surname:..... First names:..... NZMC registration number:..... Address:..... Phone No:..... Facsimile No:..... Email address:..... Cellphone No:.....	Title: Mr/Mrs/Miss/Ms/Dr NHI No:..... Surname:..... First names:..... Address:..... Gender: Male/Female DOB:..... Phone No:.....
	Details of patient's General Practitioner
	Name:..... Address:..... Phone No:.....

INITIAL APPLICATION

Prerequisites: Subsidised for use as monotherapy, maximum dose 400mg daily (tick box where appropriate):

- Diagnosis of unresectable and/or metastatic malignant gastrointestinal stromal tumour (GIST)
- Immunohistochemical documentation of c-kit (CD117) expression by the tumour

RENEWAL- Gastrointestinal stromal tumour (GIST)

Dose to be prescribed as monotherapy:	
Initial	_____mg/day
Renewal	_____mg/day

Prerequisites (tick box where appropriate)

- Compliance (prescriber determined) with imatinib and adequate clinical response (prescriber determined). Describe below.

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

Signed:..... Date:.....

DISPATCH INSTRUCTIONS FOR:

Patient details	Please send to:
Title: Mr/Mrs/Miss/Ms/Dr Surname: First names: Address: D.O.B: NHI No:	The Imatinib Co-ordinator PHARMAC P O Box 10-254 WELLINGTON Phone: 04 460 4990 Facsimile: 04 916 7571 Email: mary.chesterfield@pharmac.govt.nz

DELIVERY ADDRESS

Please send the supply of **Imatinib**:

to Address 1 below.

Address 1	If undeliverable at Address 1, please deliver to the alternative address below:
Patient General Practitioner Other Name: Address: Phone No:	Patient General Practitioner Other Name: Address: Phone No: