

CHRONIC MYELOID LEUKAEMIA TREATMENT APPLICATION FORM FOR IMATINIB/DASATINIB

Please send applications and prescriptions to:

The CML Co-ordinator
PHARMAC
P O Box 10254
Wellington

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

Patient Details (Acceptable to attach hospital sticker)			
Title (circle):	Mr/Mrs/Miss/Ms/Dr	NHI No:	
Surname:			
First Name/s:			
Address:			
Gender (circle):	Male/Female	DOB:	
Phone No:			

Details of Applying Practitioner	Details of patient's General Practitioner
Name:	Name:
NZMC reg no	Address:
Address:	
Phone No:	Phone No:
Fax No:	
Speciality (tick):	
<input type="checkbox"/> Haematology <input type="checkbox"/> Oncology	

Treatment Requested (tick Imatinib or Dasatinib)	
<input type="checkbox"/> Imatinib Dose <input style="width: 80px;" type="text"/> mg/day	OR
<input type="checkbox"/> Dasatinib Dose <input style="width: 80px;" type="text"/> mg/day	
To be prescribed as monotherapy	
Please tick boxes as applicable:	
<input type="checkbox"/> Chronic Phase (imatinib maximum dose 400mg daily) (dasatinib maximum dose 100mg daily)	
<input type="checkbox"/> Accelerated Phase (imatinib maximum dose 600mg daily) (dasatinib maximum dose 140mg daily)	
<input type="checkbox"/> Blast Crisis Phase (imatinib maximum dose 600mg daily) (dasatinib maximum dose 140mg daily)	
<input type="checkbox"/> Initial Application	<input type="checkbox"/> Renewal Application Renewal Number:
<input type="checkbox"/> CML Confirmed by Haematologist	<input type="checkbox"/> Compliance (prescriber determined) Please tick if applicable
Provide most recent results for the following where appropriate (It is acceptable to attach lab results)	
<input type="checkbox"/> Cytogenetic results provided for 3 rd renewal (and other renewals if available)	
Absolute Neutrophil count _____x10 ⁹ /L	Platelets _____x10 ⁹ /L
Test Date:	Test Date:
Peripheral blood	Bone marrow
blasts _____%	blasts _____%
basophils _____%	promyelocytes _____%
promyelocytes _____%	Ph+ metaphases _____%
FISH Ph+ score _____%	(or FISH Ph+ score) _____%
Q-PCR bcr-abl _____%	Q-PCR bcr-abl _____%
Extramedullary disease Yes <input type="checkbox"/> No <input type="checkbox"/>	
See discontinuation guidelines in Pharmaceutical Schedule	

I Confirm the above details are correct and that in signing this form I understand that I may be audited.	
Signed: _____	Date: _____

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

Please send applications and prescriptions to: The GIST Co-ordinator
 PHARMAC
 PO Box 10-254
 WELLINGTON

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

Patient Details (Acceptable to attach hospital sticker)			
Title (circle):	Mr/Mrs/Miss/Ms/Dr	NHI No:	
Surname:			
First Name/s:			
Address:			
Gender (circle):	Male/Female	DOB:	
Phone No:			

Details of Applying Practitioner		Details of patient's General Practitioner	
Name:		Name:	
NZMC reg no.		Address:	
Address:			
Phone No:		Phone No:	
Fax 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

Dose to be prescribed as monotherapy:

Initial _____ mg/day

Renewal _____ mg/day

RENEWAL – Gastrointestinal stromal tumour (GIST)

Prerequisites (tick box where appropriate)

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

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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: