

APPLICATION FOR ALTERNATE SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER Reg No:**

Reg No: First Names: First Names:

Name: Surname: Surname:

Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Letrozole

INITIAL APPLICATION - New patients

Applications only from a relevant specialist. Approvals valid for 5 years.

Prerequisites (tick boxes where appropriate)

Patient is a postmenopausal woman

and

Patient has hormone receptor positive early breast cancer

and

The patient has a very clear history of intolerance to tamoxifen

or

The use of tamoxifen is contraindicated due to a history of thromboembolic disease

INITIAL APPLICATION - Patient has had a Special Authority approval for letrozole prior to 1 December 2008

Applications only from a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

RENEWAL

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

Applications only from a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

If the patient had an approval for letrozole prior to 1 December 2008 the applicant is required to submit a fresh initial application in the first instance, not a renewal application. Please phone Ministry of Health Sector Services on 0800 243 666 for clarification if needed.

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

Signed: Date: