

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:

Rituximab

INITIAL APPLICATION - Post-transplant

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient has B-cell post-transplant lymphoproliferative disorder*

and

To be used for a maximum of 8 treatment cycles

INITIAL APPLICATION - Indolent, Low-grade lymphomas

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months.

Prerequisites (tick boxes where appropriate)

The patient has indolent low grade NHL with relapsed disease following prior chemotherapy

and

To be used for a maximum of 4 treatment cycles

or

The patient has indolent, low grade lymphoma requiring first-line systemic chemotherapy

and

To be used for a maximum of 6 treatment cycles

Note:

'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. Rituximab is not funded for Chronic lymphocytic leukaemia/small lymphocytic lymphoma.

INITIAL APPLICATION - Aggressive CD20 positive NHL

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient has treatment-naive aggressive CD20 positive NHL

and

To be used with a multi-agent chemotherapy regimen given with curative intent

and

To be used for a maximum of 8 treatment cycles

Note:

'Aggressive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia

Use next page for: Renewal - Indolent, Low-grade lymphomas and Renewal - Post-transplant

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

Signed: Date:

Post application to Ministry of Health, Private Bag 3015, Wanganui – Fax: 0800 100 131

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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

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..... Address:

.....

Fax Number: Fax Number:

Rituximab - continued

RENEWAL - Indolent, Low-grade lymphomas

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months.

Prerequisites (tick boxes where appropriate)

- The patient has had a rituximab treatment-free interval of 12 months or more
and
 The patient has indolent, low-grade NHL with relapsed disease following prior chemotherapy
and
 To be used for no more than 4 treatment cycles

Note:

'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. Rituximab is not funded for Chronic lymphocytic leukaemia/small lymphocytic lymphoma.

RENEWAL - Post-transplant

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months.

Prerequisites (tick boxes where appropriate)

- The patient has had a rituximab treatment-free interval of 12 months or more
and
 The patient has B-cell post-transplant lymphoproliferative disorder*
and
 To be used for no more than 6 treatment cycles

Note:

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: