Application Form for Candesartan tablets

Return completed to: Exceptional Circumstances
PHARMAC
PO Box 10-254
Wellington

Phone: 04-916-7553
Fax: 09-523-6870

Patient Details:
Full name of patient: ______________________________

Residential Address: ______________________________

____

Date of Birth: ______________ Daytime Phone: ______________

NHI: ______________________________

Applying Physician:
Full name: ______________________________

Address: ______________________________

Are you a GP ☐ or Specialist ☐ ?

Medicine/treatment sought

Chemical Name: candesartan

Manufacturer: AstraZeneca

Patient was on a dose of candesartan above 16 mg per day before 1 July 2004 ☐

Dosage to be used and anticipated cost per year (please tick the appropriate amount or enter an amount if another dose is required):

Dose	**Cost per year**	
20 mg (2.5 x 8 mg tablet per day) ______	$861.01	☐
24 mg (1.5 x 16 mg tablet per day) _____	$630.21	☐
32 mg (2 x 16 mg tablet per day) _______	$840.28	☐

Other dose________________________Cost per year__________________

Nominated Pharmacy – (if approval is given, from where will the patient have the prescription dispensed?)

Name: ____

Address: ____

Entry Criteria

The patient has been consulted about this use of candesartan ☐

Signature of Medical Practitioner: ________________________________

Address: ____

Date of Request: ____

Practitioners Stamp: