

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER**

Name: First Names: Name:

Address: Surname: Address:

..... DOB:

..... Address:

Fax Number: Fax Number:

NZMC No: NZMC No:

Losartan – Tab 50 mg with hydrochlorothiazide 12.5 mg (Hyzar)

INITIAL APPLICATION

Applications only from a relevant specialist or general practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

Patient has raised blood pressure

and

The use of fully funded beta blockers is contraindicated, or not well tolerated; or where use of fully funded beta blockers and diuretics are insufficient to control blood pressure adequately at appropriate doses

and

Has been treated with, and cannot tolerate two ACE inhibitors, due to persistent cough

or

Has experienced angioedema on an ACE inhibitor at any time in the past or who have experienced angioedema (even if not using an ACE inhibitor) in the last 2 years

RENEWAL

Current approval Number:.....

Applications only from a relevant specialist or general practitioner. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

Signed: Date: