

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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:

Acarbose

INITIAL APPLICATION

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

Prerequisites (tick boxes where appropriate)

Requires but is not able to tolerate metformin therapy

or

Requires metformin but metformin is contraindicated

or

Has not responded to or tolerated the maximum appropriate dose of metformin

RENEWAL

Current approval Number:.....

Applications only from a relevant specialist. 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:

Post application to Health Payments, Agreements and Compliance (HealthPAC), Private Bag 3015, Wanganui - Fax: 0800 100 131