

# APPLICATION FOR 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: .....

## Ezetimibe with Simvastatin (Vytorin)

### INITIAL APPLICATION

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

**Prerequisites** (tick boxes, and write the data requested in the space provided where appropriate)

Patient has a calculated absolute risk of cardiovascular disease >20% over 5 years

and

Patient cannot tolerate statin therapy at a dose of  $\geq 40$  mg per day

and

Patient has venous CABG

and

LDL cholesterol: .....  $\geq 2$  mmol/litre (see note)

and

LDL cholesterol: .....  $\geq 2$  mmol/litre (at least 1 week after test 1 – see note)

or

Patient does not have venous CABG

and

LDL cholesterol: .....  $\geq 2.5$  mmol/litre (see note)

and

LDL cholesterol: .....  $\geq 2.5$  mmol/litre (at least 1 week after test 1 – see note)

or

Patient has homozygous familial hypercholesterolemia, or heterozygous familial hypercholesterolemia

and

Patient has been compliant for at least two months with maximum dose statin therapy

and

LDL cholesterol: .....  $\geq 5$  mmol/litre (see note)

and

LDL cholesterol: .....  $\geq 5$  mmol/litre (at least 1 week after test 1 – see note)

Note:

Two lipid tests are required to assess LDL cholesterol levels, the tests must be at least one week apart, and be carried out in a fasted state (other than for patients with IDDM). The results for LDL cholesterol levels in both tests must be above those specified.

### RENEWAL

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

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