

# 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: .....      .....

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Fax Number: .....      Fax Number: .....

## Leuprorelin

### INITIAL APPLICATION - Breast cancer

Applications from any medical practitioner. Approvals valid for 1 year.

#### Prerequisites (tick box where appropriate)

The patient is a premenopausal woman with breast cancer

### INITIAL APPLICATION - Prostate cancer

Applications only from an oncologist, urologist or endocrinologist. Approvals valid for 1 year.

#### Prerequisites (tick box where appropriate)

The patient has advanced prostatic cancer

Note:

Not to be prescribed with an anti-androgen except for a period of three weeks, if necessary, when GnRH analogue therapy is initiated

### INITIAL APPLICATION - Endometriosis

Applications only from a gynaecologist. Approvals valid for 3 months.

#### Prerequisites (tick boxes where appropriate)

Endometriosis

and

6 months treatment with medroxyprogesterone acetate, danazol or dimetrioise has proven ineffective

or

The patient has failed to tolerate the treatment with medroxyprogesterone acetate, danazol or dimetrioise for 6 months

Note:

The maximum treatment period for a GnRH analogue is:

- 3 months to assess whether surgery is appropriate
- 3 months for infertile patients after surgery
- 6 months for patients with symptoms of endometriosis After the first 3 months patients should be assessed to determine whether there has been a satisfactory response to the first 3 months treatment

### INITIAL APPLICATION - Precocious puberty

Applications only from a paediatrician or endocrinologist. Approvals valid for 1 year.

#### Prerequisites (tick box where appropriate)

The patients is affected by gonadotropin dependent precocious puberty

**Use next page for: Renewal - Breast or prostate cancer, Renewal - Endometriosis and Renewal - Precocious puberty**

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**

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## Leuprorelin - continued

### RENEWAL - Breast or prostate cancer

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

Applications from any medical practitioner. Approvals valid for 1 year.

#### Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

If a patient had an approval for any GnRH analogue prior to 1 July 2006 the applicant is required to submit a fresh initial application, not a renewal application.

### RENEWAL - Endometriosis

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

Applications from any medical practitioner. Approvals valid for 3 months.

#### Prerequisites (tick boxes where appropriate)

There has been a satisfactory response to the first 3 months treatment

and

Surgery is inappropriate

or

The first three months of therapy did not follow surgery for infertility

Note:

If a patient had an approval for any GnRH analogue prior to 1 July 2006 the applicant is required to submit a fresh initial application, not a renewal application.

### RENEWAL - Precocious puberty

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

Applications only from a paediatrician or endocrinologist. Approvals valid for 1 year.

#### Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

If a patient had an approval for any GnRH analogue prior to 1 July 2006 the applicant is required to submit a fresh initial application, not a renewal application.

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