

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:

Desmopressin – Inj 4 µg per ml, 1 ml

INITIAL APPLICATION

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

Prerequisites (tick box where appropriate)

The patient cannot use desmopressin nasal spray or nasal drops

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