

# APPLICATION FOR ALTERNATE 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: .....

## Hormone Replacement Therapy – Systemic

### INITIAL APPLICATION

Applications only from an obstetrician, gynaecologist, general practitioner or general physician. Approvals valid for 5 years.

#### Prerequisites (tick boxes where appropriate)

- acute or significant liver disease – where oral oestrogens are contraindicated as determined by a gastroenterologist or general physician. The applicant must keep written confirmation from such a specialist with the patient's record
- or
- oestrogen induced hypertension requiring antihypertensive therapy – documented evidence must be kept on file that raised blood pressure levels or inability to control blood pressure adequately occurred post oral oestrogens
- or
- hypertriglyceridaemia – documented evidence must be kept on file that triglyceride levels increased to at least 2 x normal triglyceride levels post oral oestrogens

Note:

Prescriptions with a valid Special Authority (CHEM) number will be reimbursed at the level of the lowest priced TDDS product within the specified dose group.

### RENEWAL

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

Applications only from an obstetrician, gynaecologist, general practitioner or general physician. Approvals valid for 5 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