

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**APPLICANT** (stamp or sticker acceptable)      **PATIENT** (Either patient code or details)      **REFERRER** Reg No: .....

Reg No: ..... Code/NHI: ..... First Names: .....

Name: ..... First Names: ..... Surname: .....

Address: ..... Surname: ..... Address: .....

..... DOB: .....  
..... Address: .....

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

## Antiretrovirals

### INITIAL APPLICATION - Confirmed HIV/AIDS

Applications only from a named specialist. Approvals valid without further renewal unless notified.

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

Confirmed HIV infection

and

Symptomatic patient

or

Patient aged 12 months and under

or

Patient aged 1 to 5 years

and

CD4 counts: ..... < 1,000 cells/mm<sup>3</sup>

or

CD4 counts: ..... < 0.25 × total lymphocyte count: .....

or

Viral load counts: ..... > 100,000 copies per ml

or

Patient aged 6 years and over

and

CD4 counts: ..... < 350 cells/mm<sup>3</sup>

**Note:**

Subsidies for a combination of up to three anti-retroviral medications, including a maximum of two protease inhibitors. Combinations including ritonavir plus indinavir or saquinavir or atazanavir will be counted as one protease inhibitor for the purpose of accessing funding to anti-retrovirals.

**Use next page for: Initial application - Percutaneous exposure, Initial application - Prevention of maternal transmission and Renewal - Confirmed HIV/AIDS**

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**

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT</b> (Either patient code or details)	<b>REFERRER</b> Reg No: .....
Reg No: .....	Code/NHI: .....	First Names: .....
Name: .....	First Names: .....	Surname: .....
Address: .....	Surname: .....	Address: .....
.....	DOB: .....	.....
.....	Address: .....	.....
Fax Number: .....	.....	Fax Number: .....

## Antiretrovirals - continued

### INITIAL APPLICATION - Percutaneous exposure

Applications only from a named specialist. Approvals valid for 6 weeks.

#### Prerequisites (tick box where appropriate)

The patient has percutaneous exposure to blood known to be HIV positive

Note:

Subsidies for a combination of up to three anti-retroviral medications, including a maximum of two protease inhibitors. Combinations including ritonavir plus indinavir or saquinavir or atazanavir will be counted as one protease inhibitor for the purpose of accessing funding to anti-retrovirals.

### INITIAL APPLICATION - Prevention of maternal transmission

Applications only from a named specialist. Approvals valid for 1 year.

#### Prerequisites (tick boxes where appropriate)

Prevention of maternal foetal transmission

or

Treatment of the newborn for up to eight weeks

Note:

Subsidies for a combination of up to three anti-retroviral medications, including a maximum of two protease inhibitors. Combinations including ritonavir plus indinavir or saquinavir or atazanavir will be counted as one protease inhibitor for the purpose of accessing funding to anti-retrovirals.

Some antiretrovirals are unapproved or contraindicated for this indication. Practitioners prescribing these medications should exercise their own skill, judgement, expertise and discretion, and make their own prescribing decisions with respect to the use of a Pharmaceutical for an indication for which it is not approved or contraindicated.

### RENEWAL - Confirmed HIV/AIDS

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

Applications only from a named specialist. Approvals valid without further renewal unless notified.

#### 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: .....