

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:

Enfuvirtide

INITIAL APPLICATION

Applications only from a named specialist. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

- Confirmed HIV infection
- and
- Enfuvirtide to be given in combination with optimized background therapy (including at least 1 other antiretroviral drug that the patient has never previously been exposed to) for treatment failure
- and
- Patient has evidence of HIV replication, despite ongoing therapy
- or
- Patient has treatment-limiting toxicity to previous antiretroviral agents
- and
- Previous treatment with 3 different antiretroviral regimens has failed
- and
- Previous treatment with a non-nucleoside reverse transcriptase inhibitor has failed
- and
- Previous treatment with a nucleoside reverse transcriptase inhibitor has failed
- and
- Previous treatment with a protease inhibitor has failed

RENEWAL

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

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

Prerequisites (tick boxes where appropriate)

- Evidence of at least a 10 fold reduction in viral load at 12
- and
- 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