

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:

Clopidogrel

INITIAL APPLICATION - aspirin allergic patients

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

The patient is allergic to aspirin (see definition below)

and

The patient has:

suffered from a stroke, or transient ischaemic attack

or

experienced an acute myocardial infarction

or

experienced an episode of pain at rest of greater than 20 minutes duration due to coronary disease that required admission to hospital for at least 24 hours

or

had a troponin T or troponin I test result greater than the upper limit of the reference range

or

had a revascularisation procedure

or

experienced symptomatic peripheral vascular disease of a severity that has required specialist consultation

Note:

Aspirin allergy is defined as a history of anaphylaxis, urticaria or asthma within 4 hours of ingestion of aspirin, other salicylates or NSAIDs.

INITIAL APPLICATION - aspirin tolerant patients and aspirin naive patients

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

Prerequisites (tick boxes where appropriate)

The patient has:

experienced an acute myocardial infarction

or

had an episode of pain at rest of greater than 20 minutes duration due to coronary disease that required admission to hospital for at least 24 hours

or

had a troponin T or troponin I test result greater than the upper limit of the reference range

or

had a revascularisation procedure

INITIAL APPLICATION - patients awaiting revascularisation

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

The patient is on a waiting list or active review list for stenting, coronary artery bypass grafting, or percutaneous coronary angioplasty following acute coronary syndrome

Use next page for: Initial application - post stenting, Initial application - documented stent thrombosis, Renewal - aspirin tolerant patients, Renewal - acute coronary syndrome - aspirin tolerant patients and aspirin naive patients, Renewal - patients awaiting revascularisation, Renewal - post stenting and Renewal - documented stent thrombosis

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

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER** Reg No:

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Clopidogrel - continued

INITIAL APPLICATION - post stenting

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

The patient has had a stent inserted in the previous 4 weeks

INITIAL APPLICATION - documented stent thrombosis

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The patient has, while on treatment with aspirin or clopidogrel, experienced documented stent thrombosis.

RENEWAL - aspirin tolerant patients

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

While on treatment with aspirin the patient has experienced an additional vascular event following the recent cessation of clopidogrel

RENEWAL - acute coronary syndrome - aspirin tolerant patients and aspirin naive patients

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

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

Prerequisites (tick boxes where appropriate)

The patient has:

experienced an acute myocardial infarction

or

had an episode of pain at rest of greater than 20 minutes duration due to coronary disease that required admission to hospital for at least 24 hours

or

had a troponin T or troponin I test result greater than the upper limit of the reference range

or

had a revascularisation procedure

RENEWAL - patients awaiting revascularisation

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

The patient is on a waiting list or active review list for stenting, coronary artery bypass grafting or percutaneous coronary angioplasty following acute coronary syndrome

Use next page for: Renewal - post stenting and Renewal - documented stent thrombosis

I confirm the above details are correct and that in signing this form I understand I may be audited.

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APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER** Reg No:

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Clopidogrel - continued

RENEWAL - post stenting

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

The patient has had a stent inserted in the previous 4 weeks

RENEWAL - documented stent thrombosis

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The patient has, while on treatment with aspirin or clopidogrel, experienced documented stent thrombosis

I confirm the above details are correct and that in signing this form I understand I may be audited.

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