

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:

Losartan with or without hydrochlorothiazide

INITIAL APPLICATION - ACE inhibitor intolerance

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

Prerequisites (tick boxes where appropriate)

Patient has persistent ACE inhibitor induced cough that is not resolved by ACE inhibitor retrial (same or new ACE inhibitor)

or

Patient has a history of angioedema

INITIAL APPLICATION - Unsatisfactory response to ACE inhibitor

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

Prerequisites (tick box where appropriate)

Patient is not adequately controlled on maximum tolerated dose of an ACE inhibitor

INITIAL APPLICATION - Patient had an approval for Losartan with hydrochlorothiazide prior to 1 May 2008

Applications from any relevant practitioner. 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:

Post application to Ministry of Health, Private Bag 3015, Wanganui – Fax: 0800 100 131