

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:

Aripiprazole

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

Patient is suffering from schizophrenia or related psychoses

and

An effective dose of risperidone or quetiapine has been trialled and has been discontinued, or is in the process of being discontinued, because of unacceptable side effects

or

An effective dose of risperidone or quetiapine has been trialled and has been discontinued, or is in the process of being discontinued, because of inadequate clinical response

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 2 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