

# 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: .....

## Pegylated Interferon alpha-2B with Ribavirin

**INITIAL APPLICATION - chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV**  
Applications from any specialist. Approvals valid for 11 months.

**Prerequisites** (tick box where appropriate)

Patient has an existing Special Authority

Note:  
Existing current approvals are still valid but no new applications will be accepted.

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