

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:

Acitretin

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

Applicant is a vocationally registered dermatologist, vocationally registered general practitioner, or nurse practitioner working in a relevant scope of practice

and

Applicant has an up to date knowledge of the treatment options for psoriasis and of disorders of keratinisation and is aware of the safety issues around acitretin and is competent to prescribe acitretin

and

Patient is female and has been counselled and understands the risk of teratogenicity if acitretin is used during pregnancy and the applicant has ensured that the possibility of pregnancy has been excluded prior to the commencement of the treatment and that the patient is informed that she must not become pregnant during treatment and for a period of two years after the completion of the treatment

or

Patient is male

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

Applicant is a vocationally registered dermatologist, vocationally registered general practitioner, or nurse practitioner working in a relevant scope of practice

and

Applicant has an up to date knowledge of the treatment options for psoriasis and of disorders of keratinisation and is aware of the safety issues around acitretin and is competent to prescribe acitretin

and

Patient is female and has been counselled and understands the risk of teratogenicity if acitretin is used during pregnancy and the applicant has ensured that the possibility of pregnancy has been excluded prior to the commencement of the treatment and that the patient is informed that she must not become pregnant during treatment and for a period of two years after the completion of the treatment

or

Patient is male

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