

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:

Enoxaparin sodium

INITIAL APPLICATION - Pregnancy or Malignancy

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

Prerequisites (tick boxes where appropriate)

Low molecular weight heparin treatment is required during a patients pregnancy

or

For the treatment of venous thromboembolism where the patient has a malignancy

INITIAL APPLICATION - Venous thromboembolism other than in pregnancy or malignancy

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

Prerequisites (tick boxes where appropriate)

For the short-term treatment of venous thromboembolism prior to establishing a therapeutic INR with oral anti-coagulant treatment

or

For the prophylaxis and treatment of venous thromboembolism in high risk surgery

or

To enable cessation/re-establishment of existing warfarin treatment pre/post surgery

or

For the prophylaxis and treatment of venous thromboembolism in Acute Coronary Syndrome surgical intervention

or

To be used in association with cardioversion of atrial fibrillation

RENEWAL - Pregnancy or Malignancy

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

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

Prerequisites (tick boxes where appropriate)

Low molecular weight heparin treatment is required during a patient's pregnancy

or

For the treatment of venous thromboembolism where the patient has a malignancy

RENEWAL - Venous thromboembolism other than in pregnancy or malignancy

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

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

Prerequisites (tick box where appropriate)

Low molecular weight heparin treatment or prophylaxis is required for a second or subsequent event (surgery, ACS, cardioversion, or prior to oral anti-coagulation)

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