

# 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: .....

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Fax Number: .....      Fax Number: .....

## Entecavir

### INITIAL APPLICATION

Applications only from a gastroenterologist or infectious disease specialist. Approvals valid without further renewal unless notified.

#### Prerequisites (tick boxes where appropriate)

Patient has confirmed Hepatitis B infection (HBsAg positive for more than 6 months)

and

Patient is Hepatitis B nucleoside analogue treatment-naive

and

Entecavir dose 0.5 mg/day

and

ALT greater than upper limit of normal

or

Bridging fibrosis or cirrhosis (Metavir stage 3 or greater) on liver histology

and

HBeAg positive

or

patient has  $\geq 2,000$  IU HBV DNA units per ml and fibrosis (Metavir stage 2 or greater) on liver histology

and

No continuing alcohol abuse or intravenous drug use

and

Not co-infected with HCV, HIV or HDV

and

Neither ALT nor AST greater than 10 times upper limit of normal

and

No history of hypersensitivity to entecavir

and

No previous documented lamivudine resistance (either clinical or genotypic)

#### Note:

- Entecavir should be continued for 6 months following documentation of complete HBeAg seroconversion (defined as loss of HBeAg plus appearance of anti-HBe plus loss of serum HBV DNA) for patients who were HBeAg positive prior to commencing this agent. This period of consolidation therapy should be extended to 12 months in patients with advanced fibrosis (Metavir Stage F3 or F4).
- Entecavir should be taken on an empty stomach to improve absorption.

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**