

# 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: .....

## Mirtazapine

### INITIAL APPLICATION

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

**Prerequisites** (tick boxes where appropriate)

The patient has a severe major depressive episode

and

The patient must have had a trial of two different antidepressants and was unable to tolerate the treatments or failed to respond to an adequate dose over an adequate period of time (usually at least four weeks)

or

The patient is currently a hospital in-patient as a result of an acute depressive episode

and

The patient must have had a trial of one other antidepressant and either could not tolerate it or failed to respond to an adequate dose over an adequate period of time

### RENEWAL

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

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

**Prerequisites** (tick box where appropriate)

The patient has a high risk of relapse (prescriber determined)

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