

SPECIAL AUTHORITY FORMS

November 2009

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THE SPECIAL AUTHORITY SYSTEM

Special Authority is an application process in which a prescriber requests government subsidy for a particular person.

Criteria

The criteria for approval of Special Authority applications are included below each pharmaceutical listing. For some Special Authority pharmaceuticals, not all indications listed on the data sheets are subsidised. Criteria for each Special Authority pharmaceutical are updated regularly, based on the decision criteria of PHARMAC.

The appropriateness of the listing of a pharmaceutical in the Special Authority category will also be regularly reviewed. Applications for inclusion of further pharmaceuticals in the Special Authority category will generally be made by a pharmaceutical supplier.

Applications from Specialists

"Specialist" means, a doctor who holds a current annual practising certificate and who satisfies the criteria set out below.

1. The doctor's name appears in the Vocational Register of medical practitioners in accordance with Section 21 and 22 of the Medical Practitioners Act 1995 and who is making the application in the course of practising in that area of medicine; and the doctor's vocational branch or sub-branch is one of those listed below:
 - anaesthetics
 - cardiothoracic surgery
 - dermatology
 - diagnostic radiology
 - emergency medicine
 - general surgery
 - internal medicine
 - neurosurgery
 - obstetrics and gynaecology
 - occupational medicine
 - ophthalmology
 - otolaryngology head and neck surgery
 - orthopaedic surgery
 - paediatric surgery
 - paediatrics
 - pathology
 - plastic and reconstructive surgery
 - psychological medicine or psychiatry
 - public health medicine
 - radiation oncology
 - rehabilitation medicine
 - urology and venereology
2. The doctor is recognised by the Ministry of Health as a specialist for the purposes of the Pharmaceutical Schedule and receives remuneration from a DHB at a level which that DHB considers appropriate for specialists and who has written that Prescription in the course of practising in that area of medicine
3. The doctor is recognised by the Ministry of Health as a specialist in relation to a particular area of medicine for the purpose of writing Prescriptions and who has written the Prescription in the course of practising in that area of medicine.
4. The doctor writes the Prescription on DHB stationery and is appropriately authorised by the relevant DHB to do so.

Approval

Special Authority applications are administered by the Ministry of Health. They were formerly administered by Health Payments, Agreements and Compliance (HealthPAC), a division of the Ministry of Health. All applications should be sent, in writing, to:

Ministry of Health, Private Bag 3015, WANGANUI
 Fax: (06) 349 1983 or free fax 0800 100 131
 For inquiries, please call the Contact Centre on, free phone 0800 243 666

Each application must include:

- name and date of birth of the patient (codes for AIDS patients' applications)
- diagnosis and brief clinical details
- name of the medicine required, the form and strength of the medicine
- duration of the course of treatment
- alternative therapies that have been tried

The application must:

- be signed by the practitioner
- include the practitioner's printed name and address
- show the practitioner's Medical Council registration number
- provide evidence of the criteria as per Special Authority conditions for medicine applied for

Subsidy

Once approved, health providers can obtain the Special Authority approval details for prescribing and dispensing purposes by calling the Contact Centre on 0800 243 666.

Specialists who make an application must communicate the valid authority number to the prescriber who will be writing the prescriptions.

The authority number can provide access to subsidy, additional subsidy, or waive certain restrictions otherwise present on the pharmaceutical.

Some approvals are dependent on the availability of funding.

PANEL APPROVALS

Applications to be made on the approved forms which are available from the co-ordinator of the relevant panel:

Product	Panel
Bosentan	Pulmonary Arterial Hypertension Panel
Dasatinib	CML/GIST Co-ordinator
Dornase Alfa	Cystic Fibrosis Advisory Panel
liloprost	Pulmonary Arterial Hypertension Panel
Imatinib Mesylate	CML/GIST Co-ordinator
Imiglucerase	Gaucher's Treatment Panel
Levetiracetam	Levetiracetam Special Access Panel
Multiple Sclerosis Treatments	Multiple Sclerosis Treatment Committee
Neurontin	PHARMAC
Sildenafil	Pulmonary Arterial Hypertension Panel
<p>Panel Co-ordinator Pharmac PO Box 10 254 Wellington Phone: 04 460 4990 Facsimile: 04 460 4995 E-mail: ECPanel@Pharmac.govt.nz</p>	

Product	Panel
Growth Hormone Biosynthetic Human	Growth Hormone Committee
<p>Prof. Wayne Cutfield National Co-ordinator New Zealand Growth Hormone Committee C/- Department of Paediatrics University of Auckland Private Bag 92019 AUCKLAND</p>	

Alimentary Tract and Metabolism

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:

Budesonide – Cap 3 mg Controlled Release

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

Mild to moderate ileal, ileocaecal or proximal Crohn's disease

and

Diabetes

or

Cushingoid habitus

or

Osteoporosis where there is significant risk of fracture

or

Severe acne following treatment with conventional corticosteroid therapy

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 3 months. The patient must have had no more than 1 prior approval in the last year

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

Clinical trials for Entocort CIR use beyond three months demonstrated no improvement in relapse rate.

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

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:

Insulin Glargine

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

Patient has type 1 diabetes and has received an intensive regimen (injections at least three times a day) of an intermediate acting insulin in combination with a rapid acting insulin analogue for at least three months

and

Patient has experienced more than one unexplained severe hypoglycaemic episode in the previous 12 months (severe defined as requiring the assistance of another person)

or

Patient has experienced unexplained symptomatic nocturnal hypoglycaemia, biochemically documented at <3.0 mmol/L, more than once a month despite optimal management

or

Patient has documented severe, or continuing, systemic or local allergic reaction to existing insulins. Note this does not include hypoglycaemic episodes

RENEWAL

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

Applications only from a relevant specialist or general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

Patient is continuing to derive benefit due to reduced hypoglycaemic events whilst maintaining similar or better glycaemic control

or

Patient's allergic reaction has significantly decreased, or resolved, following the change to long-acting insulin and patient is continuing to benefit from treatment

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

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:

Acarbose

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

The patient has type 2 diabetes

and

Metformin is not tolerated, or is contraindicated

or

The patient has not responded to the maximum appropriate dose of metformin

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

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:

Pioglitazone

INITIAL APPLICATION - Patients with type 2 diabetes

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

Patient has not achieved glycaemic control on maximum doses of metformin and/or a sulphonylurea or where either or both are contraindicated or not tolerated

or

Patient is on insulin

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER Reg No:**

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Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Ursodeoxycholic Acid – Cap 300 mg

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

Primary biliary cirrhosis confirmed by antimitochondrial antibody titre (AMA) > 1:80, and raised cholestatic liver enzymes with or without raised serum IgM or, if AMA is negative, by liver biopsy

and

Patient not requiring a liver transplant (bilirubin > 170umol/l; decompensated cirrhosis)

Note:

Liver biopsy is not usually required for diagnosis but is helpful to stage the disease.

RENEWAL

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

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

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

Actigall is not an appropriate therapy for patients requiring a liver transplant (bilirubin > 170 micromol/l; decompensated cirrhosis). These patients should be referred to an appropriate transplant centre. Treatment failure – doubling of serum bilirubin levels, absence of a significant decrease in ALP or ALT and AST, development of varices, ascites or encephalopathy, marked worsening of pruritus or fatigue, histological progression by two stages, or to cirrhosis, need for transplantation.

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APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT** NHI: **REFERRER** Reg No:

Reg No: First Names: First Names:

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Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Macrogol 3350

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

the patient has problematic constipation requiring intervention with a per rectal preparation despite an adequate trial of other oral pharmacotherapies including lactulose where lactulose is not contraindicated

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

the patient is compliant and is continuing to gain benefit from treatment

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER** Reg No:

Reg No: First Names: First Names:

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Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Alpha Tocopheryl Acetate

INITIAL APPLICATION

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

Prerequisites (tick boxes where appropriate)

Cystic fibrosis patient

or

Infant or child with liver disease or short gut syndrome

and

Requires vitamin supplementation

RENEWAL

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

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

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

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:

Multivitamins (Ketovite; Ketovite; Paediatric Seravit)

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

The patient has inborn errors of metabolism

or

For use as a supplement to a ketogenic diet in patients diagnosed with epilepsy

RENEWAL

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

Patient has had a previous approval for multivitamins

Note:

Use of Paediatric Seravit is not recommended as a supplement to a ketogenic diet.

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

Blood and Blood Forming Organs

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT** NHI: **REFERRER** Reg No:

Reg No: First Names: First Names:

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Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Erythropoietin

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

patient in chronic renal failure
and
Haemoglobin: ≤ 100g/L

and

patient is not diabetic
and
glomerular filtration rate: ≤ 30ml/min

or

patient is diabetic
and
glomerular filtration rate: ≤ 45ml/min

or

patient is on haemodialysis or peritoneal dialysis

RENEWAL

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

Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

Erythropoietin beta is indicated in the treatment of anaemia associated with chronic renal failure (CRF) where no cause for anaemia other than CRF is detected and there is adequate monitoring of iron stores and iron replacement therapy.

The Cockcroft-Gault Formula may be used to estimate glomerular filtration rate (GFR) in persons 18 years and over:

GFR (ml/min) (male) = (140 - age) × Ideal Body Weight (kg) / 814 × serum creatinine (mmol/l)

GFR (ml/min) (female) = Estimated GFR (male) × 0.85

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

Clopidogrel

INITIAL APPLICATION - aspirin allergic patients

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

The patient is allergic to aspirin (see definition below)

and

The patient has:

suffered from a stroke, or transient ischaemic attack

or

experienced an acute myocardial infarction

or

experienced an episode of pain at rest of greater than 20 minutes duration due to coronary disease that required admission to hospital for at least 24 hours

or

had a troponin T or troponin I test result greater than the upper limit of the reference range

or

had a revascularisation procedure

or

experienced symptomatic peripheral vascular disease of a severity that has required specialist consultation

Note:

Aspirin allergy is defined as a history of anaphylaxis, urticaria or asthma within 4 hours of ingestion of aspirin, other salicylates or NSAIDs.

INITIAL APPLICATION - aspirin tolerant patients and aspirin naive patients

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

The patient has:

experienced an acute myocardial infarction

or

had an episode of pain at rest of greater than 20 minutes duration due to coronary disease that required admission to hospital for at least 24 hours

or

had a troponin T or troponin I test result greater than the upper limit of the reference range

or

had a revascularisation procedure

INITIAL APPLICATION - patients awaiting revascularisation

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

The patient is on a waiting list or active review list for stenting, coronary artery bypass grafting, or percutaneous coronary angioplasty following acute coronary syndrome

Use next page for: Initial application - post stenting, Initial application - documented stent thrombosis, Renewal - aspirin tolerant patients, Renewal - acute coronary syndrome - aspirin tolerant patients and aspirin naive patients, Renewal - patients awaiting revascularisation, Renewal - post stenting and Renewal - documented stent thrombosis

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

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:

Clopidogrel - continued

INITIAL APPLICATION - post stenting

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

The patient has had a stent inserted in the previous 4 weeks

INITIAL APPLICATION - documented stent thrombosis

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The patient has, while on treatment with aspirin or clopidogrel, experienced documented stent thrombosis.

RENEWAL - aspirin tolerant patients

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

While on treatment with aspirin the patient has experienced an additional vascular event following the recent cessation of clopidogrel

RENEWAL - acute coronary syndrome - aspirin tolerant patients and aspirin naive patients

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

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

The patient has:

experienced an acute myocardial infarction

or

had an episode of pain at rest of greater than 20 minutes duration due to coronary disease that required admission to hospital for at least 24 hours

or

had a troponin T or troponin I test result greater than the upper limit of the reference range

or

had a revascularisation procedure

RENEWAL - patients awaiting revascularisation

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

The patient is on a waiting list or active review list for stenting, coronary artery bypass grafting or percutaneous coronary angioplasty following acute coronary syndrome

Use next page for: Renewal - post stenting and Renewal - documented stent thrombosis

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

Clopidogrel - continued

RENEWAL - post stenting

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

The patient has had a stent inserted in the previous 4 weeks

RENEWAL - documented stent thrombosis

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The patient has, while on treatment with aspirin or clopidogrel, experienced documented stent thrombosis

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

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 patient's 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

APPLICATION FOR MANUFACTURERS PRICE 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:

Atorvastatin

INITIAL APPLICATION

Applications only from a relevant specialist or general practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

Patient has a calculated absolute risk of cardiovascular disease of at least 15% over 5 years
and

Patient has severe documented intolerance to simvastatin (blood tests are not required)
or

Patient has been compliant with a dose of simvastatin of 80 mg per day for at least 2 months
and

Patient has venous CABG

and

LDL cholesterol test 1: \geq 2 mmol/litre

and

LDL cholesterol test 2: \geq 2 mmol/litre (at least 1 week after test 1)

or

Patient does not have venous CABG

and

LDL cholesterol test 1: \geq 2.5 mmol/litre

and

LDL cholesterol test 2: \geq 2.5 mmol/litre (at least 1 week after test 1)

Note:

To confirm that cholesterol levels are not still improving, two lipid tests must be carried out during treatment with simvastatin 80 mg, and have results for LDL cholesterol that have reduced by <10% in the second test. The tests must be carried out while the patient is in a fasted state (with the exception of patients with IDDM).

The following indications of intolerance to simvastatin, are known as class effects for all statins, and hence are likely to mean that the patient may also be intolerant of atorvastatin:

- Constipation, flatulence (may occur in >1% of patients)
- Asthenia, abdominal pain, headache (may occur in >1% of patients)
- Myopathy, rhabdomyolysis (may occur in <3% of patients)
- Elevated serum transaminase levels (may occur in <1% of patients)

Statins have been shown to be generally well tolerated in clinical studies, with the rate of discontinuation due to adverse reactions being less than 5%, and similar to the discontinuation rate for patients taking a placebo.

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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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:

Pravastatin

INITIAL APPLICATION - Confirmed HIV/AIDS

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

Patient has dyslipidaemia and an absolute 5 year cardiovascular risk of 15% or greater

and

Confirmed HIV infection

and

Patient is being treated with an HIV protease inhibitor

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

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:

Ezetimibe

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

ezetimibe is to be used in combination with simvastatin
or
 ezetimibe is to be used without a statin

and

Patient has a calculated absolute risk of cardiovascular disease >20% over 5 years
and
 Patient cannot tolerate statin therapy at a dose of ≥ 40 mg per day
and

Patient has venous CABG
and
LDL cholesterol: ≥ 2 mmol/litre (see note)
and
LDL cholesterol: ≥ 2 mmol/litre (at least 1 week after test 1 – see note)

or

Patient does not have venous CABG
and
LDL cholesterol: ≥ 2.5 mmol/litre (see note)
and
LDL cholesterol: ≥ 2.5 mmol/litre (at least 1 week after test 1 – see note)

or

Patient has homozygous familial hypercholesterolemia, or heterozygous familial hypercholesterolemia
and
 Patient has been compliant for at least two months with maximum dose statin therapy
and
LDL cholesterol: ≥ 5 mmol/litre (see note)
and
LDL cholesterol: ≥ 5 mmol/litre (at least 1 week after test 1 – see note)

Note:

Two lipid tests are required to assess LDL cholesterol levels, the tests must be at least one week apart, and be carried out in a fasted state (other than for patients with IDDM). The results for LDL cholesterol levels in both tests must be above those specified.

Use next page for: Renewal

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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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:

Ezetimibe - continued

RENEWAL

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

Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

ezetimibe is to be used in combination with simvastatin

or

ezetimibe is to be used without a statin

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER Reg No:**

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Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Ezetimibe with Simvastatin (Vytorin)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

Patient has a calculated absolute risk of cardiovascular disease >20% over 5 years

and

Patient cannot tolerate statin therapy at a dose of ≥ 40 mg per day

and

Patient has venous CABG

and

LDL cholesterol: ≥ 2 mmol/litre (see note)

and

LDL cholesterol: ≥ 2 mmol/litre (at least 1 week after test 1 – see note)

or

Patient does not have venous CABG

and

LDL cholesterol: ≥ 2.5 mmol/litre (see note)

and

LDL cholesterol: ≥ 2.5 mmol/litre (at least 1 week after test 1 – see note)

or

Patient has homozygous familial hypercholesterolemia, or heterozygous familial hypercholesterolemia

and

Patient has been compliant for at least two months with maximum dose statin therapy

and

LDL cholesterol: ≥ 5 mmol/litre (see note)

and

LDL cholesterol: ≥ 5 mmol/litre (at least 1 week after test 1 – see note)

Note:

Two lipid tests are required to assess LDL cholesterol levels, the tests must be at least one week apart, and be carried out in a fasted state (other than for patients with IDDM). The results for LDL cholesterol levels in both tests must be above those specified.

RENEWAL

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

Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

Cardiovascular System

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:

Losartan with or without hydrochlorothiazide

INITIAL APPLICATION - ACE inhibitor intolerance

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

Patient has persistent ACE inhibitor induced cough that is not resolved by ACE inhibitor retrial (same or new ACE inhibitor)

or

Patient has a history of angioedema

INITIAL APPLICATION - Unsatisfactory response to ACE inhibitor

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

Patient is not adequately controlled on maximum tolerated dose of an ACE inhibitor

INITIAL APPLICATION - Patient had an approval for Losartan with hydrochlorothiazide prior to 1 May 2008

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

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:

Candesartan

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

Patient with congestive heart failure

and

Has been treated with, and cannot tolerate, two ACE inhibitors, due to persistent cough

or

Has experienced angioedema on an ACE inhibitor at any time in the past or who have experienced angioedema (even if not using an ACE inhibitor) in the last 2 years

or

Patient with raised blood pressure

and

Use of fully funded beta blockers or diuretics are contraindicated; or not well tolerated; or insufficient to control blood pressure adequately at appropriate doses

and

Has been treated with, and cannot tolerate, two ACE inhibitors, due to persistent cough

or

Has experienced angioedema on an ACE inhibitor at any time in the past or who have experienced angioedema (even if not using an ACE inhibitor) in the last 2 years

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

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:

Midodrine

INITIAL APPLICATION

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

Prerequisites (tick boxes where appropriate)

- Disabling orthostatic hypotension not due to drugs
and
 Patient has tried fludrocortisone (unless contra-indicated) with unsatisfactory results
and
 Patient has tried non pharmacological treatments such as support hose, increased salt intake, exercise, and elevation of head and trunk at night

Note:

Treatment should be started with small doses and titrated upwards as necessary.

Hypertension should be avoided, and the usual target is a standing systolic blood pressure of 90 mm Hg.

RENEWAL

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

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

Prerequisites (tick box where appropriate)

- The treatment remains appropriate and the patient is benefiting from treatment

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

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:

Perhexiline Maleate

INITIAL APPLICATION

Applications only from a cardiologist or general physician. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

Refractory angina

and

Patient is already on maximal anti-anginal therapy

RENEWAL

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

Applications only from a cardiologist or general physician. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

Dermatologicals

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:

Isotretinoin

INITIAL APPLICATION

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

Prerequisites (tick boxes where appropriate)

- Patient has had an adequate trial on other available treatments and has failed these treatments or these are contraindicated
- and
- 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 acne and is aware of the safety issues around isotretinoin and is competent to prescribe isotretinoin
- and
- Patient is female and has been counselled and understands the risk of teratogenicity if isotretinoin 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 one month after the completion of the treatment
- or
- Patient is male

Note:

Applicants are recommended to either have used or be familiar with using a decision support tool accredited by their professional body.

RENEWAL

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

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

Prerequisites (tick boxes where appropriate)

- Patient has had an adequate trial on other available treatments and has failed these treatments or these are contraindicated
- and
- 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 acne and is aware of the safety issues around isotretinoin and is competent to prescribe isotretinoin
- and
- Patient is female and has been counselled and understands the risk of teratogenicity if isotretinoin 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 one month after the completion of the treatment
- or
- Patient is male

Note:

Applicants are recommended to either have used or be familiar with using a decision support tool accredited by their professional body.

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

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

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:

Imiquimod

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 4 months.

Prerequisites (tick boxes where appropriate)

- The patient has external anogenital warts and podophyllotoxin has been tried and failed (or is contraindicated)
or
 The patient has external anogenital warts and podophyllotoxin is unable to be applied accurately to the site
or
 The patient has confirmed superficial basal cell carcinoma where other standard treatments, including surgical excision, are contraindicated or inappropriate

Note:

Superficial basal cell carcinoma

- Surgical excision remains first-line treatment for superficial basal cell carcinoma as it has a higher cure rate than imiquimod and allows histological assessment of tumour clearance.
- Imiquimod has not been evaluated for the treatment of superficial basal cell carcinoma within 1 cm of the hairline, eyes, nose, mouth or ears.
- Imiquimod is not indicated for recurrent, invasive, infiltrating, or nodular basal cell carcinoma.

External anogenital warts

- Imiquimod is only indicated for external genital and perianal warts (condyloma acuminata).

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 4 months.

Prerequisites (tick boxes where appropriate)

- Inadequate response to initial treatment for anogenital warts
or
 New confirmed superficial basal cell carcinoma where other standard treatments, including surgical excision, are contraindicated or inappropriate
or
 Inadequate response to initial treatment for superficial basal cell carcinoma

Note:

Confirmation that the lesion is a superficial basal cell carcinoma should be obtained using a biopsy

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

Genito-Urinary System

APPLICATION FOR ALTERNATE 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:

Combined oral contraceptives; Progestogen-only contraceptives (Circle one)

INITIAL APPLICATION

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

Prerequisites (tick boxes where appropriate)

Patient is on a Social Welfare benefit

or

Patient has an income no greater than the benefit

and

Has tried at least one of the fully funded options and has been unable to tolerate it

RENEWAL

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

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

Prerequisites (tick boxes where appropriate)

Patient is on a Social Welfare benefit

or

Patient has an income no greater than the benefit

Note:

The approval numbers of Special Authorities approved after 1 November 1999 are interchangeable between Mercilon, Marvelon, Minulet and Femodene.

The additional subsidy will fund Mercilon, Marvelon, Minulet and Femodene up to the manufacturer's price for each of these products as identified on the Schedule at 1 November 1999.

Special Authorities approved before 1 November 1999 remain valid until the expiry date and can be renewed providing that women are still either:

- on a Social Welfare benefit; or
- have an income no greater than the benefit.

The approval numbers of Special Authorities approved before 1 November 1999 are interchangeable for products within the combined oral contraceptives and progestogen-only contraceptives groups, except Loette and Microgynon 20 ED

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

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:

Finasteride

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

Patient has symptomatic benign prostatic hyperplasia

and

The patient is intolerant of non-selective alpha blockers or these are contraindicated

or

Symptoms are not adequately controlled with non-selective alpha blockers

Note:

Patients with enlarged prostates are the appropriate candidates for therapy with finasteride.

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

Hormone Preparations - Systemic Excluding Contraceptive Hormones

APPLICATION FOR ALTERNATE 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:

Hormone Replacement Therapy – Systemic

INITIAL APPLICATION

Applications only from an obstetrician, gynaecologist, general practitioner or general physician. Approvals valid for 5 years.

Prerequisites (tick boxes where appropriate)

- acute or significant liver disease – where oral oestrogens are contraindicated as determined by a gastroenterologist or general physician. The applicant must keep written confirmation from such a specialist with the patient's record
- or
- oestrogen induced hypertension requiring antihypertensive therapy – documented evidence must be kept on file that raised blood pressure levels or inability to control blood pressure adequately occurred post oral oestrogens
- or
- hypertriglyceridaemia – documented evidence must be kept on file that triglyceride levels increased to at least 2 x normal triglyceride levels post oral oestrogens

Note:

Prescriptions with a valid Special Authority (CHEM) number will be reimbursed at the level of the lowest priced TDDS product within the specified dose group.

RENEWAL

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

Applications only from an obstetrician, gynaecologist, general practitioner or general physician. Approvals valid for 5 years.

Prerequisites (tick box where appropriate)

- The treatment remains appropriate and the patient is benefiting from treatment

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

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:

Levonorgestrel – releasing intrauterine system 20µg/24 hr

INITIAL APPLICATION - No previous use

Applications only from a relevant specialist or general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The patient has a clinical diagnosis of heavy menstrual bleeding

and

The patient has failed to respond to or is unable to tolerate other appropriate pharmaceutical therapies as per the Heavy Menstrual Bleeding Guidelines

and

serum ferritin level: < 16 µg/l (within the last 12 months)

or

haemoglobin level: < 120 g/l

Note:

Applications are not to be made for use in patients as contraception except where they meet the above criteria.

INITIAL APPLICATION - Previous use before 1 October 2002

Applications only from a relevant specialist or general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The patient had a clinical diagnosis of heavy menstrual bleeding

and

Patient demonstrated clinical improvement of heavy menstrual bleeding

and

Applicant to state date of the previous insertion:

Note:

Applications are not to be made for use in patients as contraception except where they meet the above criteria.

RENEWAL

Current approval Number (if known):

Applications only from a relevant specialist or general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

Patient demonstrated clinical improvement of heavy menstrual bleeding

or

Previous insertion was removed or expelled within 3 months of insertion

and

Applicant to state date of the previous insertion:

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

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:

Buserelin

INITIAL APPLICATION - Breast cancer

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

Prerequisites (tick box where appropriate)

The patient is a premenopausal woman with breast cancer

INITIAL APPLICATION - Prostate cancer

Applications only from an oncologist, urologist or endocrinologist. Approvals valid for 1 year.

Prerequisites (tick box where appropriate)

The patient has advanced prostatic cancer

Note:

Not to be prescribed with an anti-androgen except for a period of three weeks, if necessary, when GnRH analogue therapy is initiated.

INITIAL APPLICATION - Endometriosis

Applications only from a gynaecologist. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

Endometriosis

and

6 months treatment with medroxyprogesterone acetate, danazol or dimetrioise has proven ineffective

or

The patient has failed to tolerate the treatment with medroxyprogesterone acetate, danazol or dimetrioise for 6 months

Note:

The maximum treatment period for a GnRH analogue is:

- 3 months to assess whether surgery is appropriate
- 3 months for infertile patients after surgery
- 6 months for patients with symptoms of endometriosis After the first 3 months patients should be assessed to determine whether there has been a satisfactory response to the first 3 months treatment.

INITIAL APPLICATION - Precocious puberty

Applications only from a paediatrician or endocrinologist. Approvals valid for 1 year.

Prerequisites (tick box where appropriate)

The patient is affected by gonadotropin dependent precocious puberty

Use next page for: Renewal - Breast or prostate cancer, Renewal - Endometriosis and Renewal - Precocious puberty

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

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:

Buserelin - continued

RENEWAL - Breast or prostate cancer

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

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

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

If a patient had an approval for any GnRH analogue prior to 1 July 2006 the applicant is required to submit a fresh initial application, not a renewal application.

RENEWAL - Endometriosis

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

Applications from any medical practitioner. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

There has been a satisfactory response to the first 3 months treatment

and

Surgery is inappropriate

or

The first three months of therapy did not follow surgery for infertility

Note:

If a patient had an approval for any GnRH analogue prior to 1 July 2006 the applicant is required to submit a fresh initial application, not a renewal application.

RENEWAL - Precocious puberty

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

Applications only from a paediatrician or endocrinologist. Approvals valid for 1 year.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

If a patient had an approval for any GnRH analogue prior to 1 July 2006 the applicant is required to submit a fresh initial application, not a renewal application.

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

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:

Desmopressin – Inj 4 µg per ml, 1 ml

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

The patient cannot use desmopressin nasal spray or nasal drops

RENEWAL

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

Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

APPLICATION FOR WAIVER OF RULE 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:

Cabergoline

INITIAL APPLICATION

Applications only from an obstetrician, endocrinologist or gynaecologist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

The patient has pathological hyperprolactinemia

RENEWAL

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

Applications only from an obstetrician, endocrinologist or gynaecologist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

Infections - Agents for Systemic Use

APPLICATION FOR WAIVER OF RULE 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:

Azithromycin

INITIAL APPLICATION

Applications only from a respiratory specialist or paediatrician. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- The applicant is part of multidisciplinary team experienced in the management of cystic fibrosis
- and
- The patient has been definitively diagnosed with cystic fibrosis*
- and
- The patient has chronic infection with *Pseudomonas aeruginosa* or *Pseudomonas* related gram negative organisms as defined by two positive respiratory tract cultures at least three months apart*
- and
- The patient has negative cultures for non-tuberculous mycobacteria

Note:

Caution is advised if using azithromycin as an antibiotic in the treatment of cystic fibrosis patients with pneumonia.

Testing for non-tuberculosis mycobacteria should occur annually.

Indications marked with * are Unapproved Indications (refer to Section A: General Rules, Part I (Interpretations and Definitions) and Part IV (Miscellaneous Provisions) rule 4.6).

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

APPLICATION FOR WAIVER OF RULE 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:

Clarithromycin

INITIAL APPLICATION - Mycobacterial infections

Applications only from a respiratory specialist, infectious disease specialist or paediatrician. Approvals valid for 2 years.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

Mycobacterium Avium Intracellulare Complex infections in patient with AIDS

or

Atypical and drug-resistant mycobacterial infection

or

Prophylaxis against disseminated Mycobacterium Avium Intracellulare Complex infection

and

HIV infection

and

CD4 count: ≤ 50 cells/mm³

RENEWAL - Mycobacterial infections

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

Applications only from a respiratory specialist, infectious disease specialist or paediatrician. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

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:

Lamivudine

INITIAL APPLICATION

Applications only from a gastroenterologist, infectious disease specialist, paediatrician or general physician. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

HBsAg positive for more than 6 months

and

HBeAg positive or HBV DNA positive defined as > 100,000 copies per ml by quantitative PCR at a reference laboratory

and

ALT greater than twice upper limit of normal or bridging fibrosis or cirrhosis (Metavir stage 3 or 4 or equivalent) on liver histology
clinical/radiological evidence of cirrhosis

or

HBV DNA positive cirrhosis prior to liver transplantation

or

HBsAg positive and have had a liver, kidney, heart, lung or bone marrow transplant

or

Hepatitis B surface antigen positive (HbsAg) patient who is receiving chemotherapy for a malignancy, or who has received such treatment within the previous two months

and

No continuing alcohol abuse or intravenous drug use

and

Not coinfecting with HCV or HDV

and

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

and

No history of hypersensitivity to lamivudine

and

No previous lamivudine therapy with genotypically proven lamivudine resistance

Use next page for: Renewal

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

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:

Lamivudine - continued

RENEWAL

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

Applications only from a gastroenterologist, infectious disease specialist, paediatrician or general physician. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

Renewal for patients who have maintained continuous treatment and response to lamivudine

Have maintained continuous treatment with lamivudine
and
 Most recent test result shows continuing biochemical response (normal ALT)
and
 HBV DNA <100,00 copies per ml by quantitative PCR at a reference laboratory

or

Renewal when given in combination with adefovir dipivoxil for patients with cirrhosis and resistance to lamivudine

Lamivudine to be used in combination with adefovir dipivoxil
and
 Patient is cirrhotic
and
Documented resistance to lamivudine, defined as:
 Patient has raised serum ALT (> 1 x ULN)
and
 Patient has HBV DNA greater than 100,000 copies per mL, or viral load = 10 fold over nadir
and
 Detection of M204I or M204V mutation

or

Renewal when given in combination with adefovir dipivoxil for patients with resistance to adefovir dipivoxil

Lamivudine to be used in combination with adefovir dipivoxil
and
Documented resistance to adefovir, defined as:
 Patient has raised serum ALT (> 1 x ULN)
and
 Patient has HBV DNA greater than 100,000 copies per mL, or viral load = 10 fold over nadir
and
 Detection of N236T or A181T/V mutation

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

Adefovir dipivoxil

INITIAL APPLICATION

Applications only from a gastroenterologist or infectious disease specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

Patient has confirmed Hepatitis B infection (HBsAg+)

and

Documented resistance to lamivudine, defined as:

Patient has raised serum ALT (> 1 × ULN)

and

Patient has HBV DNA greater than 100,000 copies per mL, or viral load ≥ 10 fold over nadir

and

Detection of M204I or M204V mutation

and

Patient is cirrhotic

and

adefovir dipivoxil to be used in combination with lamivudine

or

Patient is not cirrhotic

and

adefovir dipivoxil to be used as monotherapy

RENEWAL

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

Applications only from a gastroenterologist or infectious disease specialist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

In the opinion of the treating physician, treatment remains appropriate and patient is benefiting from treatment

Note:

Lamivudine should be added to adefovir dipivoxil if a patient develops documented resistance to adefovir dipivoxil, defined as:

1. raised serum ALT (> 1 × ULN); and
2. HBV DNA greater than 100,000 copies per mL, or viral load ≥ 10 fold over nadir; and
3. Detection of N236T or A181T/V mutation.

Adefovir dipivoxil should be stopped 6 months following HBeAg seroconversion for patients who were HBeAg+ prior to commencing adefovir dipivoxil.

The recommended dose of adefovir dipivoxil is no more than 10mg daily.

In patients with renal insufficiency adefovir dipivoxil dose should be reduced in accordance with the datasheet guidelines.

Adefovir dipivoxil should be avoided in pregnant women and children.

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

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

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:

Valaciclovir

INITIAL APPLICATION - recurrent genital herpes

Applications from any medical practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

The patient has genital herpes with 2 or more breakthrough episodes in any 6 month period while treated with aciclovir 400 mg twice daily

RENEWAL - recurrent genital herpes

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

Applications from any medical practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

INITIAL APPLICATION - ophthalmic zoster

Applications from any medical practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The patient has previous history of ophthalmic zoster and the patient is at risk of vision impairment

INITIAL APPLICATION - CMV prophylaxis

Applications from any medical practitioner. Approvals valid for 3 months.

Prerequisites (tick box where appropriate)

The patient has undergone organ transplantation

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT** (Either patient code or details) **REFERRER** Reg No:

Reg No: Code/NHI: First Names:

Name: First Names: Surname:

Address: Surname: Address:

..... DOB:
..... Address:

Fax Number: Fax Number:

Antiretrovirals

INITIAL APPLICATION - Confirmed HIV/AIDS

Applications only from a named specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

Confirmed HIV infection

and

Symptomatic patient

or

Patient aged 12 months and under

or

Patient aged 1 to 5 years

and

CD4 counts: < 1,000 cells/mm³

or

CD4 counts: < 0.25 × total lymphocyte count:

or

Viral load counts: > 100,000 copies per ml

or

Patient aged 6 years and over

and

CD4 counts: < 350 cells/mm³

Note:

Subsidies for a combination of up to three anti-retroviral medications, including a maximum of two protease inhibitors. Combinations including ritonavir plus indinavir or saquinavir or atazanavir will be counted as one protease inhibitor for the purpose of accessing funding to anti-retrovirals.

Use next page for: Initial application - Percutaneous exposure, Initial application - Prevention of maternal transmission and Renewal - Confirmed HIV/AIDS

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable)	PATIENT (Either patient code or details)	REFERRER Reg No:
Reg No:	Code/NHI:	First Names:
Name:	First Names:	Surname:
Address:	Surname:	Address:
.....	DOB:
.....	Address:
Fax Number:	Fax Number:

Antiretrovirals - continued

INITIAL APPLICATION - Percutaneous exposure
Applications only from a named specialist. Approvals valid for 6 weeks.

Prerequisites (tick box where appropriate)

The patient has percutaneous exposure to blood known to be HIV positive

Note:

Subsidies for a combination of up to three anti-retroviral medications, including a maximum of two protease inhibitors. Combinations including ritonavir plus indinavir or saquinavir or atazanavir will be counted as one protease inhibitor for the purpose of accessing funding to anti-retrovirals.

INITIAL APPLICATION - Prevention of maternal transmission
Applications only from a named specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

Prevention of maternal foetal transmission

or

Treatment of the newborn for up to eight weeks

Note:

Subsidies for a combination of up to three anti-retroviral medications, including a maximum of two protease inhibitors. Combinations including ritonavir plus indinavir or saquinavir or atazanavir will be counted as one protease inhibitor for the purpose of accessing funding to anti-retrovirals.

Some antiretrovirals are unapproved or contraindicated for this indication. Practitioners prescribing these medications should exercise their own skill, judgement, expertise and discretion, and make their own prescribing decisions with respect to the use of a Pharmaceutical for an indication for which it is not approved or contraindicated.

RENEWAL - Confirmed HIV/AIDS

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

Applications only from a named specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

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:

Enfuvirtide

INITIAL APPLICATION

Applications only from a named specialist. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

- Confirmed HIV infection
and
 Enfuvirtide to be given in combination with optimized background therapy (including at least 1 other antiretroviral drug that the patient has never previously been exposed to) for treatment failure
and
- Patient has evidence of HIV replication, despite ongoing therapy
or
 Patient has treatment-limiting toxicity to previous antiretroviral agents
- and**
 Previous treatment with 3 different antiretroviral regimens has failed
and
- Previous treatment with a non-nucleoside reverse transcriptase inhibitor has failed
and
 Previous treatment with a nucleoside reverse transcriptase inhibitor has failed
and
 Previous treatment with a protease inhibitor has failed

RENEWAL

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

Applications only from a named specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- Evidence of at least a 10 fold reduction in viral load at 12
and
 The treatment remains appropriate and the patient is benefiting from treatment

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

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-2A

INITIAL APPLICATION - chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV

Applications from any specialist. Approvals valid for 48 weeks.

Prerequisites (tick boxes where appropriate)

Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection

or

Patient has chronic hepatitis C and is co-infected with HIV

Note:

- Consider stopping treatment if there is absence of a virological response (defined as at least a 2-log reduction in viral load) following 12 weeks of treatment since this is predictive of treatment failure.
- Consider reducing treatment to 24 weeks if serum HCV RNA level at Week 4 is undetectable by sensitive PCR assay (less than 50IU/ml) AND Baseline serum HCV RNA is less than 400,000IU/ml

INITIAL APPLICATION - chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV

Applications from any specialist. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

Patient has chronic hepatitis C, genotype 2 or 3 infection

Use next page for: Initial application - Hepatitis B

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

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-2A - continued

INITIAL APPLICATION - Hepatitis B

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 48 weeks.

Prerequisites (tick boxes where appropriate)

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

and

Patient is Hepatitis B treatment-naive

and

ALT > 2 times Upper Limit of Normal

and

HBV DNA < 10 log₁₀ IU/ml

and

HBeAg positive

or

serum HBV DNA ≥ 2,000 units/ml and significant fibrosis (≥ Metavir Stage F2)

and

Compensated liver disease

and

No continuing alcohol abuse or intravenous drug use

and

Not co-infected with HCV, HIV or HDV

and

Neither ALT nor AST > 10 times upper limit of normal

and

No history of hypersensitivity or contraindications to pegylated interferon

Note:

- Approved dose is 180 mcg once weekly.
- The recommended dose of Pegylated Interferon-alpha 2a is 180 mcg once weekly.
- In patients with renal insufficiency (calculated creatinine clearance less than 50ml/min), Pegylated Interferon-alpha 2a dose should be reduced to 135 mcg once weekly.
- In patients with neutropaenia and thrombocytopenia, dose should be reduced in accordance with the datasheet guidelines.
- Pegylated Interferon-alpha 2a is not approved for use in children.

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

**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

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:

Interferon Alpha-2A with ribavirin

INITIAL APPLICATION

Applications from any specialist. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

patient has chronic hepatitis C (all genotypes)

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

Musculoskeletal System

APPLICATION FOR MANUFACTURERS PRICE 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:

Anti-inflammatory Non Steroidal Drugs (NSAIDs)

INITIAL APPLICATION

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

Prerequisites (tick boxes where appropriate)

Inflammatory arthritis (including osteoarthritis with an inflammatory component)

and

Stabilised and are well controlled on the particular NSAID medication

RENEWAL

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

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

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

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:

Etanercept

INITIAL APPLICATION

Applications only from a named specialist or rheumatologist. Approvals valid for 4 months.

Prerequisites (tick boxes where appropriate)

- To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance
and
 Patient diagnosed with Juvenile Idiopathic Arthritis (JIA)
and
 Patient has had severe active polyarticular course JIA for 6 months duration or longer
and
 Patient has tried and not responded to at least three months of oral or parenteral methotrexate (at a dose of 10-20mg/m² weekly or at the maximum tolerated dose) in combination with oral corticosteroids (prednisone 0.25 mg/kg or at the maximum tolerated dose)
and
 Patient has tried and not responded to at least three months of oral or parenteral methotrexate (at a dose of 10-15mg/m² weekly or at the maximum tolerated dose) in combination with one other disease-modifying agent

- Patient has persistent symptoms of poorly-controlled and active disease in at least 20 active, swollen, tender joints
or
 Patient has persistent symptoms of poorly-controlled and active disease in at least four active joints from the following: wrist, elbow, knee, ankle, shoulder, cervical spine, hip

and
 Physician's global assessment indicating severe disease

- and**
 The patient or their legal guardian consents to details of their treatment being held on a central registry and has signed a consent form outlining conditions of ongoing treatment

Note:

A patient declaration form http://www.pharmac.govt.nz/special_authority_forms/SA0667-declaration.pdf must be signed by the legal guardian of the patient and the prescriber in the presence of a witness (over 18 years of age)

RENEWAL

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

Applications only from a named specialist or rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- Subsidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance

and
 Following 4 months initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline

or
 On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

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

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:

Adalimumab

INITIAL APPLICATION - rheumatoid arthritis

Applications only from a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- Patient has had severe and active erosive rheumatoid arthritis for six months duration or longer
- and
- Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance
- and
- Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose
- and
- Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with at least two of the following (triple therapy): sulphasalazine, prednisone at a dose of at least 7.5 mg per day, azathioprine, intramuscular gold, or hydroxychloroquine sulphate (at maximum tolerated doses)
- and
- Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of cyclosporin alone or in combination with another agent
- or
- Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in combination with another agent
- and
- Patient has persistent symptoms of poorly controlled and active disease in at least 20 active, swollen, tender joints
- or
- Patient has persistent symptoms of poorly controlled and active disease in at least four active joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
- and
- Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application
- or
- C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months

Use next page for: Initial application - Crohn's disease, Initial application - severe chronic plaque psoriasis, Initial application - ankylosing spondylitis, Initial application - psoriatic arthritis, Renewal - rheumatoid arthritis, Renewal - Crohn's disease, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

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:

Adalimumab - continued

INITIAL APPLICATION - Crohn's disease
Applications only from a gastroenterologist. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

Patient has severe active Crohn's disease
and

Patient has a Crohn's Disease Activity Index (CDAI) score of greater than or equal to 300
or
 Patient has extensive small intestine disease affecting more than 50 cm of the small intestine
or
 Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection
or
 Patient has an ileostomy or colostomy, and has intestinal inflammation

and

Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior systemic therapy with immunomodulators at maximum tolerated doses (unless contraindicated) and corticosteroids

and

Surgery (or further surgery) is considered to be clinically inappropriate

INITIAL APPLICATION - severe chronic plaque psoriasis
Applications only from a dermatologist. Approvals valid for 4 months.

Prerequisites (tick boxes where appropriate)

Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 15, where lesions have been present for at least 6 months from the time of initial diagnosis
or
 Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis

and

Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, cyclosporin, or acitretin

and

A PASI assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course

and

The most recent PASI assessment is no more than 1 month old at the time of application

Note:

"Inadequate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 15, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face, hand or foot, at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.

Use next page for: Initial application - ankylosing spondylitis, Initial application - psoriatic arthritis, Renewal - rheumatoid arthritis, Renewal - Crohn's disease, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

Adalimumab - continued

INITIAL APPLICATION - ankylosing spondylitis

Applications only from a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- Patient has a confirmed diagnosis of ankylosing spondylitis present for more than six months
- and
- Patient has low back pain and stiffness that is relieved by exercise but not by rest
- and
- Patient has bilateral sacroiliitis demonstrated by plain radiographs, CT or MRI scan
- and
- Patient's ankylosing spondylitis has not responded adequately to treatment with two or more non-steroidal anti-inflammatory drugs (NSAIDs), in combination with anti-ulcer therapy if indicated, while patient was undergoing at least 3 months of an exercise regimen supervised by a physiotherapist
- and
- Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI)
- or
- Patient has limitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and gender (see Notes)
- and
- A Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 6 on a 0-10 scale
- and
- An elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour
- or
- A C-reactive protein (CRP) level greater than 15 mg per litre

Note:
The BASDAI must have been determined at the completion of the 3 month exercise trial, but prior to ceasing NSAID treatment. The BASDAI, ESR and CRP measures must be no more than 1 month old at the time of initial application.
Average normal chest expansion corrected for age and gender:

- 18-24 years - Male: 7.0 cm; Female: 5.5 cm
- 25-34 years - Male: 7.5 cm; Female: 5.5 cm
- 35-44 years - Male: 6.5 cm; Female: 4.5 cm
- 45-54 years - Male: 6.0 cm; Female: 5.0 cm
- 55-64 years - Male: 5.5 cm; Female: 4.0 cm
- 65-74 years - Male: 4.0 cm; Female: 4.0 cm
- 75+ years - Male: 3.0 cm; Female: 2.5 cm

Use next page for: Initial application - psoriatic arthritis, Renewal - rheumatoid arthritis, Renewal - Crohn's disease, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

Adalimumab - continued

INITIAL APPLICATION - psoriatic arthritis

Applications only from a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- Patient has had severe active psoriatic arthritis for six months duration or longer
- and
- Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose
- and
- Patient has tried and not responded to at least three months of sulphasalazine at a dose of at least 2 g per day or leflunomide at a dose of up to 20 mg daily (or maximum tolerated doses)
- and

- Patient has persistent symptoms of poorly controlled and active disease in at least 20 active, swollen, tender joints
- or
- Patient has persistent symptoms of poorly controlled and active disease in at least four active joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip

- and
- Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application
 - or
 - Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour
 - or
 - ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months

RENEWAL - rheumatoid arthritis

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

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- Applicant is a rheumatologist
- or
- Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment

- and
- Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance
 - and
 - Following 4 months initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
 - or
 - On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

Use next page for: Renewal - Crohn's disease, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

Adalimumab - continued

RENEWAL - Crohn's disease

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

Applications only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

Applicant is a gastroenterologist

or

Applicant is a Practitioner and confirms that a gastroenterologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment

and

The treatment remains appropriate and the patient is benefiting from treatment

RENEWAL - severe chronic plaque psoriasis

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

Applications only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

Applicant is a dermatologist

or

Applicant is a Practitioner and confirms that a dermatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment

and

Patient has "whole body" severe chronic plaque psoriasis

and

Following each prior adalimumab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-adalimumab treatment baseline value

or

Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot

and

Following each prior adalimumab treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values

or

Following each prior adalimumab treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-adalimumab treatment baseline value

Note:

An adalimumab treatment course is defined as a minimum of 12 weeks adalimumab treatment.

Use next page for: Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

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:

Adalimumab - continued

RENEWAL - ankylosing spondylitis

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

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

Applicant is a rheumatologist

or

Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment

and

Following 12 weeks of adalimumab treatment, BASDAI has improved by 4 or more points from pre-adalimumab baseline on a 10 point scale, or by 50%, whichever is less

and

ESR or CRP is within the normal range

and

Physician considers that the patient has benefited from treatment and that continued treatment is appropriate

RENEWAL - psoriatic arthritis

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

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

Applicant is a rheumatologist

or

Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment

and

Following 4 months initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the treating physician

or

The patient demonstrates at least a continuing 50% improvement in active joint count from baseline and a clinically significant response to prior adalimumab treatment in the opinion of the treating physician

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

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:

Alendronate Tab 70 mg - with or without Cholecalciferol

INITIAL APPLICATION - Underlying cause -- Osteoporosis

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- History of one significant osteoporotic fracture demonstrated radiologically and documented bone mass density (BMD) ≥ 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score ≤ -2.5)
- or
- History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age
- or
- History of two significant osteoporotic fractures demonstrated radiologically
- or
- Documented T-Score ≤ -3.0
- or
- A 10-year risk of hip fracture $\geq 3\%$, calculated using a published risk assessment algorithm (e.g. FRAX or Dubbo) which incorporates BMD measurements

INITIAL APPLICATION - Underlying cause -- glucocorticosteroid therapy

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

Prerequisites (tick boxes where appropriate)

- The patient is receiving systemic glucocorticosteroid therapy (≥ 5 mg per day prednisone equivalents) and has already received or is expected to receive therapy for at least three months
- and
- The patient has documented BMD ≥ 1.5 standard deviations below the mean normal value in young adults (i.e. T-Score ≤ -1.5)
 - or
 - The patient has a history of one significant osteoporotic fracture demonstrated radiologically

Use next page for: Renewal - Underlying cause was, and remains, glucocorticosteroid therapy and Renewal - Underlying cause was glucocorticosteroid therapy but patient now meets the 'Underlying cause - osteoporosis' criteria

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

Alendronate Tab 70 mg - with or without Cholecalciferol - continued

RENEWAL - Underlying cause was, and remains, glucocorticosteroid therapy

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

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

Prerequisites (tick box where appropriate)

The patient is continuing systemic glucocorticosteroid therapy (≥ 5 mg per day prednisone equivalents)

RENEWAL - Underlying cause was glucocorticosteroid therapy but patient now meets the 'Underlying cause - osteoporosis' criteria

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

History of one significant osteoporotic fracture demonstrated radiologically and documented bone mass density (BMD) ≥ 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score ≤ -2.5)

or

History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age

or

History of two significant osteoporotic fractures demonstrated radiologically

or

Documented T-Score ≤ -3.0

or

A 10-year risk of hip fracture $\geq 3\%$, calculated using a published risk assessment algorithm (e.g. FRAX or Dubbo) which incorporates BMD measurements

Note:

1. Evidence used by National Institute for Health and Clinical Excellence (NICE) guidance indicates that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score ≤ -2.5 , and therefore do not require BMD measurement for treatment with bisphosphonates.
2. Osteoporotic fractures are the incident events for severe (established) osteoporosis, and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
3. In line with the Australian guidelines for funding alendronate, a vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

Alendronate for Paget's Disease (Alendronate Tab 40 mg)

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

Paget's disease

and

Bone or articular pain

or

Bone deformity

or

Bone, articular or neurological complications

or

Asymptomatic disease, but risk of complications due to site (base of skull, spine, long bones of lower limbs)

or

Preparation for orthopaedic surgery

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

Nervous System

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:

Lignocaine with Prilocaine

INITIAL APPLICATION

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

Prerequisites (tick box where appropriate)

the patient is a child with a chronic medical condition requiring frequent injections or venepuncture

RENEWAL

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

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

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER** Reg No:

Reg No: First Names: First Names:

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Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Fentanyl patches

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

Patient is terminally ill and is opioid-responsive

and

is unable to take oral medication

or

is intolerant to morphine, or morphine is contraindicated

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

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:

Mianserin Hydrochloride

INITIAL APPLICATION

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

Prerequisites (tick boxes where appropriate)

Depression

and

Co-existent bladder neck obstruction

or

Cardiovascular disease

RENEWAL

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

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

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

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:

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Fax Number: Fax Number:

Venlafaxine

INITIAL APPLICATION

Applications only from a relevant specialist or vocationally registered general practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

The patient has 'treatment-resistant' depression

and

The patient must have had a trial of two different antidepressants and 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 failed to respond to an adequate dose over an adequate period of time

RENEWAL

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

Applications from any medical 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

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:

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:

Vigabatrin

INITIAL APPLICATION - new patients

Applications from any relevant practitioner. Approvals valid for 15 months.

Prerequisites (tick boxes where appropriate)

Patient has infantile spasms

or

Patient has epilepsy

and

Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents

or

Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents

and

Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter)

or

It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields

Note:

"Optimal treatment with other antiepilepsy agents" is defined as treatment with other antiepilepsy agents which are indicated and clinically appropriate for the patient, given in adequate doses for the patient's age, weight, and other features affecting the pharmacokinetics of the drug with good evidence of compliance.

Vigabatrin is associated with a risk of irreversible visual field defects, which may be asymptomatic in the early stages.

INITIAL APPLICATION - patient has had an approval for gabapentin, lamotrigine, topiramate or vigabatrin for epilepsy prior to 1 August 2007

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

Patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life from gabapentin, topiramate, vigabatrin and or lamotrigine

and

Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for the duration of treatment with vigabatrin

or

It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields

Note:

As a guideline, clinical trials have referred to a notional 50% reduction in seizure frequency as an indicator of success with anticonvulsant therapy and have assessed quality of life from the patient's perspective.

Vigabatrin is associated with a risk of irreversible visual field defects, which may be asymptomatic in the early stages.

Use next page for: Renewal

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

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:

Vigabatrin - continued

RENEWAL

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life

and

Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin

or

It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields

Note:

As a guideline, clinical trials have referred to a notional 50% reduction in seizure frequency as an indicator of success with anticonvulsant therapy and have assessed quality of life from the patient's perspective.

Vigabatrin is associated with a risk of irreversible visual field defects, which may be asymptomatic in the early stages.

If the patient had an approval for gabapentin, lamotrigine, topiramate or vigabatrin for epilepsy prior to 1 August 2007 the applicant is required to submit a fresh initial application in the first instance, not a renewal application.

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

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:

Gabapentin

INITIAL APPLICATION - Epilepsy - new patients

Applications from any relevant practitioner. Approvals valid for 15 months.

Prerequisites (tick boxes where appropriate)

- Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents
or
 Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents

Note:

"Optimal treatment with other antiepilepsy agents" is defined as treatment with other antiepilepsy agents which are indicated and clinically appropriate for the patient, given in adequate doses for the patient's age, weight, and other features affecting the pharmacokinetics of the drug with good evidence of compliance.

INITIAL APPLICATION - Epilepsy - patient has had an approval for gabapentin, lamotrigine, topiramate or vigabatrin for epilepsy prior to 1 August 2007

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

- The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life from gabapentin, topiramate, vigabatrin and/or lamotrigine

Note:

As a guideline, clinical trials have referred to a notional 50% reduction in seizure frequency as an indicator of success with anticonvulsant therapy and have assessed quality of life from the patient's perspective.

INITIAL APPLICATION - Neuropathic pain - new patients

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites (tick box where appropriate)

- The patient has tried and failed, or has been unable to tolerate, treatment with a tricyclic antidepressant

INITIAL APPLICATION - Neuropathic pain - patient has had an approval for gabapentin for neuropathic pain prior to 1 August 2007

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

Prerequisites (tick boxes where appropriate)

- The patient has demonstrated a marked improvement in their control of pain (prescriber determined)
or
 The patient has previously demonstrated clinical responsiveness to gabapentin and has now developed neuropathic pain in a new site

Use next page for: Renewal - Epilepsy and Renewal - Neuropathic pain

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

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:

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Fax Number: Fax Number:

Gabapentin - continued

RENEWAL - Epilepsy

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life

Note:

As a guideline, clinical trials have referred to a notional 50% reduction in seizure frequency as an indicator of success with anticonvulsant therapy and have assessed quality of life from the patient's perspective.

If the patient had an approval for gabapentin, lamotrigine, topiramate or vigabatrin for epilepsy prior to 1 August 2007 the applicant is required to submit a fresh initial application in the first instance, not a renewal application.

RENEWAL - Neuropathic pain

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

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

Prerequisites (tick boxes where appropriate)

The patient has demonstrated a marked improvement in their control of pain (prescriber determined)

or

The patient has previously demonstrated clinical responsiveness to gabapentin and has now developed neuropathic pain in a new site

Note:

If the patient had an approval for gabapentin for neuropathic pain prior to 1 August 2007 the applicant is required to submit a fresh initial application in the first instance, not a renewal application.

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

**APPLICATION FOR MANUFACTURERS PRICE
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:

Domperidone

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

The patient is terminally ill and requires control of nausea and vomiting

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

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:

Hyoscine (Scopolamine)

INITIAL APPLICATION

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

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

Control of intractable nausea, vomiting, or inability to swallow saliva in the treatment of malignancy or chronic disease

and

Patient cannot tolerate or does not adequately respond to oral anti-nausea agents

and

The applicant must specify the underlying malignancy or chronic disease:

RENEWAL

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

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

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

APPLICATION FOR WAIVER OF RULE 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:

Ondansetron

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

The patient is undergoing prolonged treatment with highly emetogenic chemotherapy and/or highly emetogenic radiation therapy for the treatment of malignancy

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

The patient is undergoing prolonged treatment with highly emetogenic chemotherapy and/or highly emetogenic radiation therapy for the treatment of malignancy

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

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:

Aprepitant

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

The patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

The patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy

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

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:

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Fax Number: Fax Number:

Olanzapine tabs

INITIAL APPLICATION

Applications only from a psychiatrist. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

Patient presents with first episode schizophrenia or related psychoses

or

Patient suffering from schizophrenia and related psychoses or acute mania in bipolar disorder who is likely to benefit from antipsychotic treatment

and

An effective dose of risperidone had been trialled and has been discontinued because of unacceptable side effects

or

An effective dose of risperidone had been trialled and has been discontinued because of inadequate clinical response after 4 weeks

or

The patient has suffered from an acute episode of schizophrenia or bipolar mania and has been treated with olanzapine short-acting intra-muscular injection

RENEWAL

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

Applications only from a psychiatrist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

Initial prescriptions to be written by psychiatrists or psychiatric registrars and subsequent prescriptions can be written by General Practitioners.

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

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:

Aripiprazole

INITIAL APPLICATION

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

Prerequisites (tick boxes where appropriate)

Patient is suffering from schizophrenia or related psychoses

and

An effective dose of risperidone or quetiapine has been trialled and has been discontinued, or is in the process of being discontinued, because of unacceptable side effects

or

An effective dose of risperidone or quetiapine has been trialled and has been discontinued, or is in the process of being discontinued, because of inadequate clinical response

RENEWAL

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

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

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

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:

Risperidone microspheres

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- The patient has schizophrenia or other psychotic disorder
- and
- Has tried but failed to comply with treatment using oral atypical antipsychotic agents
- and
- Has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- The patient has had less than 12 months treatment with risperidone microspheres
 - and
 - There is no clinical reason to discontinue treatment
- or
- The initiation of risperidone microspheres has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of risperidone microspheres

Note:

Risperidone microspheres should ideally be used as monotherapy (i.e. without concurrent use of any other antipsychotic medication). In some cases, it may be clinically appropriate to attempt to treat a patient with typical antipsychotic agents in depot injectable form before trialing risperidone microspheres.

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

Risperidone orally disintegrating tablets

INITIAL APPLICATION - Acute situations

Applications from any relevant practitioner. Approvals valid for 6 weeks.

Prerequisites (tick boxes where appropriate)

For a non-adherent patient on oral therapy with standard risperidone tablets or risperidone oral liquid

and

The patient is under direct supervision for administration of medicine

INITIAL APPLICATION - Chronic situations

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

Prerequisites (tick boxes where appropriate)

The patient is unable to take standard risperidone tablets or oral liquid, or once stabilized refuses to take risperidone tablets or oral liquid

and

The patient is under direct supervision for administration of medicine

RENEWAL

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

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

Prerequisites (tick boxes where appropriate)

The patient is unable to take standard risperidone tablets or oral liquid, or once stabilized refuses to take risperidone tablets or oral liquid

and

The patient is under direct supervision for administration of medicine

Note:

Risperdal Quicklets cost significantly more than risperidone tablets and should only be used where necessary.

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

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:

Olanzapine wafers

INITIAL APPLICATION

Applications only from a psychiatrist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- The patient meets the current criteria for standard olanzapine tablets
and
 The patient is unable to take standard olanzapine tablets, or once stabilized refuses to take olanzapine tablets; or the patient is non-adherent to oral therapy with standard olanzapine tablets
and
 The patient is under direct supervision for administration of medicine

RENEWAL

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

Applications only from a psychiatrist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- The patient is unable to take standard olanzapine tablets, or once stabilized refuses to take olanzapine tablets
and
 The patient is under direct supervision for administration of medicine

Note:

Initial prescriptions to be written by psychiatrists and subsequent prescriptions can be written by psychiatric registrars or General Practitioners.

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

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:

Buspirone Hydrochloride

INITIAL APPLICATION

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

Prerequisites (tick boxes where appropriate)

- For use only as an anxiolytic
and
 Other agents are contraindicated or have failed

RENEWAL

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

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

Prerequisites (tick box where appropriate)

- The treatment remains appropriate and the patient is benefiting from treatment

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

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:

Dexamphetamine Sulphate

INITIAL APPLICATION - ADHD in patients 5 or over – new patients

Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

ADHD (Attention Deficit and Hyperactivity Disorder) patients aged 5 years or over

and

Diagnosed according to DSM-IV or ICD 10 criteria

and

Applicant is a paediatrician or psychiatrist

or

Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

and

Provide name of the recommending specialist:

INITIAL APPLICATION - ADHD in patients 5 or over - patient has had an approval for dexamphetamine for ADHD prior to 1 April 2008

Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

Applicant is a paediatrician or psychiatrist

or

Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

and

Provide name of the recommending specialist:

INITIAL APPLICATION - ADHD in patients under 5 – new patients

Applications only from a paediatrician or psychiatrist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

ADHD (Attention Deficit and Hyperactivity Disorder) patients under 5 years of age

and

Diagnosed according to DSM-IV or ICD 10 criteria

Use next page for: Initial application - ADHD in patients under 5 - patient has had an approval for dexamphetamine for ADHD in patients under 5 prior to 1 April 2008, Initial application - Narcolepsy – new patients, Initial application - Narcolepsy - patient has had an approval for dexamphetamine for narcolepsy prior to 1 April 2008, Renewal - ADHD in patients 5 or over, Renewal - ADHD in patients under 5 and Renewal - Narcolepsy

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

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:

Dexamphetamine Sulphate - continued

INITIAL APPLICATION - ADHD in patients under 5 - patient has had an approval for dexamphetamine for ADHD in patients under 5 prior to 1 April 2008

Applications only from a paediatrician or psychiatrist. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

INITIAL APPLICATION - Narcolepsy – new patients

Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.

Prerequisites (tick box where appropriate)

The patient suffers from narcolepsy

INITIAL APPLICATION - Narcolepsy - patient has had an approval for dexamphetamine for narcolepsy prior to 1 April 2008

Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment.

Use next page for: Renewal - ADHD in patients 5 or over, Renewal - ADHD in patients under 5 and Renewal - Narcolepsy

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

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER Reg No:**

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Name: Surname: Surname:

Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Dexamphetamine Sulphate - continued

RENEWAL - ADHD in patients 5 or over

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

Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment
and

Applicant is a paediatrician or psychiatrist
or

Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient
and
Provide name of the recommending specialist:

Note:
If the patient had an approval for dexamphetamine for ADHD prior to 1 April 2008 the applicant is required to submit a fresh initial application in the first instance, not a renewal application. Please phone the Contact Centre on 0800 243 666 for clarification if needed.

RENEWAL - ADHD in patients under 5

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

Applications only from a paediatrician or psychiatrist. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:
If the patient had an approval for dexamphetamine for ADHD in patients under 5 prior to 1 April 2008 the applicant is required to submit a fresh initial application in the first instance, not a renewal application. Please phone the Contact Centre on 0800 243 666 for clarification if needed.

RENEWAL - Narcolepsy

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

Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:
If the patient had an approval for dexamphetamine for narcolepsy prior to 1 April 2008 the applicant is required to submit a fresh initial application in the first instance, not a renewal application. Please phone the Contact Centre on 0800 243 666 for clarification if needed.

I confirm the above details are correct and that in signing this form I understand I may be audited.

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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:

Methylphenidate Hydrochloride (Rubifen; Rubifen SR; Ritalin; Ritalin SR)

INITIAL APPLICATION - ADHD in patients 5 or over – new patients

Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

ADHD (Attention Deficit and Hyperactivity Disorder) patients aged 5 years or over

and

Diagnosed according to DSM-IV or ICD 10 criteria

and

Applicant is a paediatrician or psychiatrist

or

Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

and

Provide name of the recommending specialist:

INITIAL APPLICATION - ADHD in patients 5 or over - patient has had an approval for methylphenidate for ADHD prior to 1 April 2008

Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

Applicant is a paediatrician or psychiatrist

or

Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

and

Provide name of the recommending specialist:

INITIAL APPLICATION - ADHD in patients under 5 – new patients

Applications only from a paediatrician or psychiatrist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

ADHD (Attention Deficit and Hyperactivity Disorder) patients under 5 years of age

and

Diagnosed according to DSM-IV or ICD 10 criteria

Use next page for: Initial application - ADHD in patients under 5 - patient has had an approval for methylphenidate for ADHD in patients under 5 prior to 1 April 2008, Initial application - Narcolepsy – new patients, Initial application - Narcolepsy - patient has had an approval for methylphenidate for narcolepsy prior to 1 April 2008, Renewal - ADHD in patients 5 or over, Renewal - ADHD in patients under 5 and Renewal - Narcolepsy

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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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:

Methylphenidate Hydrochloride (Rubifen; Rubifen SR; Ritalin; Ritalin SR) - continued

INITIAL APPLICATION - ADHD in patients under 5 - patient has had an approval for methylphenidate for ADHD in patients under 5 prior to 1 April 2008

Applications only from a paediatrician or psychiatrist. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

INITIAL APPLICATION - Narcolepsy – new patients

Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.

Prerequisites (tick box where appropriate)

The patient suffers from narcolepsy

INITIAL APPLICATION - Narcolepsy - patient has had an approval for methylphenidate for narcolepsy prior to 1 April 2008

Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment.

Use next page for: Renewal - ADHD in patients 5 or over, Renewal - ADHD in patients under 5 and Renewal - Narcolepsy

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

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:

Methylphenidate Hydrochloride (Rubifen; Rubifen SR; Ritalin; Ritalin SR) - continued

RENEWAL - ADHD in patients 5 or over

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

Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

Applicant is a paediatrician or psychiatrist

or

Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

and

Provide name of the recommending specialist:

Note:

If the patient had an approval for methylphenidate for ADHD prior to 1 April 2008 the applicant is required to submit a fresh initial application in the first instance, not a renewal application. Please phone the Contact Centre on 0800 243 666 for clarification if needed.

RENEWAL - ADHD in patients under 5

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

Applications only from a paediatrician or psychiatrist. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

If the patient had an approval for methylphenidate for ADHD in patients under 5 prior to 1 April 2008 the applicant is required to submit a fresh initial application in the first instance, not a renewal application. Please phone the Contact Centre on 0800 243 666 for clarification if needed.

RENEWAL - Narcolepsy

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

Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

If the patient had an approval for methylphenidate for narcolepsy prior to 1 April 2008 the applicant is required to submit a fresh initial application in the first instance, not a renewal application. Please phone the Contact Centre on 0800 243 666 for clarification if needed.

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

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:

Naltrexone

INITIAL APPLICATION
Applications from any medical practitioner. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

Patient is currently enrolled in a recognised comprehensive treatment programme for alcohol dependence
and
 Applicant works in a community Alcohol and Drug Service contracted to one of the 21 District Health Boards or accredited against the New Zealand Alcohol and Other Drug Sector Standard or the National Mental Health Sector Standard

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

Applications from any medical practitioner. Approvals valid for 3 months. The patient must have had no more than 1 prior approval in the last 12 months

Prerequisites (tick boxes where appropriate)

Compliance with the medication (prescriber determined)
and

Patient is still unstable and requires further treatment
or
 Patient achieved significant improvement but requires further treatment
or
 Patient is well controlled but requires maintenance therapy

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

Methylphenidate Hydrochloride Extended Release (Concerta; Ritalin LA)

INITIAL APPLICATION

Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

ADHD (Attention Deficit and Hyperactivity Disorder)

and

Diagnosed according to DSM-IV or ICD 10 criteria

and

Applicant is a paediatrician or psychiatrist

or

Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

and

Provide name of the recommending specialist:

and

Patient is taking a currently subsidised formulation of methylphenidate hydrochloride (immediate-release or sustained-release) which has not been effective due to significant administration and/or compliance difficulties

or

There is significant concern regarding the risk of diversion or abuse of immediate-release methylphenidate hydrochloride

RENEWAL

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

Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

Applicant is a paediatrician or psychiatrist

or

Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

and

Provide name of the recommending specialist:

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

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:

Atomoxetine

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

Patient has ADHD (Attention Deficit and Hyperactivity Disorder) diagnosed according to DSM-IV or ICD 10 criteria

and

Once-daily dosing

and

Treatment with a subsidised formulation of a stimulant has resulted in the development or worsening of serious adverse reactions or where the combination of subsidised stimulant treatment with another agent would pose an unacceptable medical risk

or

Treatment with a subsidised formulation of a stimulant has resulted in worsening of co-morbid substance abuse or there is a significant risk of diversion with subsidised stimulant therapy

or

An effective dose of a subsidised formulation of a stimulant has been trialled and has been discontinued because of inadequate clinical response

and

The patient will not be receiving treatment with atomoxetine in combination with a subsidised formulation of a stimulant, except for the purposes of transitioning from subsidised stimulant therapy to atomoxetine

RENEWAL

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

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

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

A "subsidised formulation of a stimulant" refers to currently subsidised methylphenidate hydrochloride tablet formulations (immediate-release, sustained-release and extended-release) or dexamphetamine sulphate tablets.

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

Oncology Agents and Immunosuppressants

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:

Oxaliplatin

INITIAL APPLICATION

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient has metastatic colorectal cancer
and
 To be used for first or second line use as part of a combination chemotherapy regimen

or

The patient has stage III (Duke's C) colorectal* cancer
and
 Adjuvant oxaliplatin to be given in combination with a fluoropyrimidine (fluorouracil or capecitabine)

RENEWAL

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient requires continued therapy

or

The tumour has relapsed and requires re-treatment

Note:

Indications marked with * are Unapproved Indications, oxaliplatin is indicated for adjuvant treatment of stage III (Duke's C) colon cancer after complete resection of the primary tumour.

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

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:

Capecitabine

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient has advanced gastrointestinal malignancy

or

The patient has metastatic breast cancer*

or

The patient has stage III (Duke's stage C) colorectal*# cancer and undergone surgery

or

The patient has poor venous access or needle phobia*

and

The patient requires a substitute for single agent fluoropyrimidine*

RENEWAL

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

Applications only from a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient requires continued therapy

or

The tumour has relapsed and requires re-treatment

Note:

Indications marked with * are Unapproved Indications, # capecitabine is approved for stage III (Duke's stage C) colon cancer.

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER Reg No:**

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Name: Surname: Surname:

Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Irinotecan

INITIAL APPLICATION

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient has metastatic colorectal cancer

and

To be used for first or second line use as part of a combination chemotherapy regimen

or

As single agent chemotherapy in fluropyrimidine-relapsed disease

RENEWAL

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient requires continued therapy

or

The tumour has relapsed and requires re-treatment

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

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:

Gemcitabine Hydrochloride

INITIAL APPLICATION

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- The patient has non small cell lung carcinoma (stage IIIa, or above)
- or
- The patient has advanced malignant mesothelioma*
- or
- The patient has advanced pancreatic carcinoma
- or
- The patient has ovarian, fallopian tube* or primary peritoneal carcinoma*
- or
- The patient has advanced transitional cell carcinoma of the urothelial tract (locally advanced or metastatic)

RENEWAL

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- The patient requires continued therapy
- or
- The tumour has relapsed and requires re-treatment

Note:
Indications marked with a * are Unapproved Indications.

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER** Reg No:

Reg No: First Names: First Names:

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Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Vinorelbine

INITIAL APPLICATION

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient has metastatic breast cancer

or

The patient has non-small cell lung cancer (stage IIIa, or above)

or

The patient has stage IB-IIIa non-small cell lung cancer
and
 Vinorelbine is to be given as adjuvant treatment in combination with cisplatin
and
 The patient has good performance status (WHO/ECOG grade 0-1)

RENEWAL

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient requires continued therapy

or

The tumour has relapsed and requires re-treatment

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

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:

Docetaxel

INITIAL APPLICATION

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient has ovarian*, fallopian* or primary peritoneal cancer*
and
 Has not received prior chemotherapy
or
 Has received prior chemotherapy but has not previously been treated with taxanes

or

The patient has metastatic breast cancer

or

The patient has early breast cancer
and
 Docetaxel is to be given concurrently with trastuzumab

or

The patient has non small-cell lung cancer
and
 Has advanced disease (stage IIIa or above)
or
 Is receiving combined chemotherapy and radiotherapy

or

The patient has small-cell lung cancer*
and
 Docetaxel is to be used as second-line therapy

RENEWAL

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient has metastatic breast cancer, non small-cell lung cancer, or small-cell lung cancer*
and

The patient requires continued therapy
or
 The tumour has relapsed and requires re-treatment

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

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:

Note:
indications marked with * are Unapproved Indications.

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

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:

Anagrelide Hydrochloride

INITIAL APPLICATION

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient has primary thrombocythaemia

and

is at high risk (previous thromboembolic disease, bleeding or platelet count >1500/ml)

or

is intolerant or refractory to hydroxyurea or interferon

RENEWAL

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

It is recommended that treatment with anagrelide be initiated only on the recommendation of a haematologist.

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

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:

Thalidomide

INITIAL APPLICATION - for new patients

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient has refractory, progressive or relapsed multiple myeloma

and

The patient has received prior chemotherapy

INITIAL APPLICATION - for patients receiving thalidomide prior to 1 January 2006

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The patient was receiving treatment with thalidomide for multiple myeloma on or before 31 December 2005

RENEWAL

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The patient has obtained a response from treatment during the initial approval period

Note:

Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier.
Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen.

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

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:

Temozolomide

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 10 months.

Prerequisites (tick boxes where appropriate)

- Patient has newly diagnosed glioblastoma multiforme
and
 Temozolomide is to be (or has been) given concomitantly with radiotherapy
and
 Following concomitant treatment temozolomide is to be used for a maximum of six cycles of 5 days treatment, at a maximum dose of 200 mg/m²

Note:

Temozolomide is not subsidised for the treatment of relapsed glioblastoma multiforme. Reapplications will not be approved.

Studies of temozolomide show that its benefit is predominantly in those patients with a good performance status (WHO grade 0 or 1 or Karnofsky score >80), and in patients who have had at least a partial resection of the tumour.

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

APPLICATION FOR ALTERNATE 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:

Letrozole

INITIAL APPLICATION - New patients

Applications only from a relevant specialist. Approvals valid for 5 years.

Prerequisites (tick boxes where appropriate)

Patient is a postmenopausal woman

and

Patient has hormone receptor positive early breast cancer

and

The patient has a very clear history of intolerance to tamoxifen

or

The use of tamoxifen is contraindicated due to a history of thromboembolic disease

INITIAL APPLICATION - Patient has had a Special Authority approval for letrozole prior to 1 December 2008

Applications only from a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

RENEWAL

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

Applications only from a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

If the patient had an approval for letrozole prior to 1 December 2008 the applicant is required to submit a fresh initial application in the first instance, not a renewal application. Please phone Ministry of Health Sector Services on 0800 243 666 for clarification if needed.

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

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:

Octreotide (somatostatin analogue)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

Acromegaly
and
 Patient has failed surgery, radiotherapy, bromocriptine and other oral therapies

or

VIPomas and Glucagonomas – for patients who are seriously ill in order to improve their clinical state prior to definitive surgery

or

Gastrinoma
and
 Patient has failed surgery
or
 Patient in metastatic disease after H2 antagonists (or proton pump inhibitors) have failed

or

Insulinomas
and
 Surgery is contraindicated or has failed

or

For pre-operative control of hypoglycaemia and for maintenance therapy

or

Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis)
and
 Disabling symptoms not controlled by maximal medical therapy

Note:

The use of octreotide in patients with fistulae, oesophageal varices, miscellaneous diarrhoea and hypotension will not be funded as a Special Authority item

RENEWAL

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

Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

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:

Bicalutamide

INITIAL APPLICATION

Applications from any medical practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The patient has advanced prostate cancer

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

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:

Mycophenolate

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

Renal transplant recipient

or

Heart transplant recipient

or

Liver transplant recipient

or

Patient has an organ transplant and has severe tophaceous gout making azathioprine unsuitable

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

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:

Rituximab

INITIAL APPLICATION - Post-transplant

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient has B-cell post-transplant lymphoproliferative disorder*

and

To be used for a maximum of 8 treatment cycles

INITIAL APPLICATION - Indolent, Low-grade lymphomas

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months.

Prerequisites (tick boxes where appropriate)

The patient has indolent low grade NHL with relapsed disease following prior chemotherapy

and

To be used for a maximum of 4 treatment cycles

or

The patient has indolent, low grade lymphoma requiring first-line systemic chemotherapy

and

To be used for a maximum of 6 treatment cycles

Note:

'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. Rituximab is not funded for Chronic lymphocytic leukaemia/small lymphocytic lymphoma.

INITIAL APPLICATION - Aggressive CD20 positive NHL

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient has treatment-naive aggressive CD20 positive NHL

and

To be used with a multi-agent chemotherapy regimen given with curative intent

and

To be used for a maximum of 8 treatment cycles

Note:

'Aggressive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia

Use next page for: Renewal - Indolent, Low-grade lymphomas and Renewal - Post-transplant

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER Reg No:**

Reg No: First Names: First Names:

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Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Rituximab - continued

RENEWAL - Indolent, Low-grade lymphomas

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months.

Prerequisites (tick boxes where appropriate)

- The patient has had a rituximab treatment-free interval of 12 months or more
and
 The patient has indolent, low-grade NHL with relapsed disease following prior chemotherapy
and
 To be used for no more than 4 treatment cycles

Note:

'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. Rituximab is not funded for Chronic lymphocytic leukaemia/small lymphocytic lymphoma.

RENEWAL - Post-transplant

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months.

Prerequisites (tick boxes where appropriate)

- The patient has had a rituximab treatment-free interval of 12 months or more
and
 The patient has B-cell post-transplant lymphoproliferative disorder*
and
 To be used for no more than 6 treatment cycles

Note:

Indications marked with * are Unapproved Indications.

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER Reg No:**

Reg No: First Names: First Names:

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Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Trastuzumab

INITIAL APPLICATION - metastatic breast cancer
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

The patient has metastatic breast cancer expressing HER-2 IHC 3+ or FISH+

RENEWAL - metastatic breast cancer
Current approval Number (if known):.....

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

The patient has metastatic breast cancer
and
 The cancer has not progressed

INITIAL APPLICATION - early breast cancer
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

The patient has early breast cancer expressing HER 2 IHC 3+ or FISH +
and
 Maximum cumulative dose of 20mg/kg (9 weeks treatment)*
and
 Trastuzumab is to be given concurrently with adjuvant taxane chemotherapy*
and
 Trastuzumab is not to be given concurrently with anthracycline chemotherapy

Note:
indications marked with * are Unapproved Indications.
It is recommended that for early breast cancer trastuzumab be administered concurrently with docetaxel prior to anthracyclines as per the FinHer regimen (Joensuu H, Kellokumpu-Lehtinen P, Bono P, et al. Adjuvant docetaxel or vinorelbine with or without trastuzumab for breast cancer. N Engl J Med 2006;354(8):809-20).

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

Tacrolimus

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The patient is an organ transplant recipient

Note:
Subsidy applies for either primary or rescue therapy.

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER** Reg No:

Reg No: First Names: First Names:

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..... Address:

.....

Fax Number: Fax Number:

Sirolimus (Rapamune)

INITIAL APPLICATION

Applications from any medical practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

The drug is to be used for rescue therapy for an organ transplant recipient

Note:

Rescue therapy defined as unresponsive to calcineurin inhibitor treatment as defined by refractory rejection; or intolerant to calcineurin inhibitor treatment due to any of the following:

- GFR < 30 ml/min; or
- Rapidly progressive transplant vasculopathy; or
- Rapidly progressive obstructive bronchiolitis; or
- HUS or TTP; or
- Leukoencephalopathy; or
- Significant malignant disease

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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Respiratory System and Allergies

**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:

Bee Venom Allergy Treatment; Wasp venom allergy treatment (Circle one)

INITIAL APPLICATION
Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

RAST or skin test positive
and
 Patient has had severe generalised reaction to the sensitising agent

RENEWAL
Current approval Number (if known):.....
Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

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:

Inhaled Corticosteroids with Long-Acting Beta-Adrenoceptor Agonists

INITIAL APPLICATION

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

Prerequisites (tick boxes where appropriate)

Patient is a child under the age of 12
and

Has, for 3 months of more, been treated with:

An inhaled long-acting beta adrenoceptor agonist
and

Inhaled corticosteroids at a dose of at least 400 µg per day beclomethasone or budesonide, or 200 µg per day fluticasone

and

The prescriber considers that the patient would receive additional clinical benefit from switching to a combination product

or

Patient is over the age of 12
and

Has, for 3 months of more, been treated with:

An inhaled long-acting beta adrenoceptor agonist
and

Inhaled corticosteroids at a dose of at least 800 µg per day beclomethasone or budesonide, or 500 µg per day fluticasone

and

The prescriber considers that the patient would receive additional clinical benefit from switching to a combination product

RENEWAL

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

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

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

Tiotropium Bromide

INITIAL APPLICATION

Applications only from a general practitioner or relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

To be used for the long-term maintenance treatment of bronchospasm and dyspnoea associated with COPD

and

In addition to standard treatment, the patient has trialed a dose of at least 40 µg ipratropium q.i.d for one month

and

The patient's breathlessness according to the Medical Research Council (UK) dyspnoea scale is:

Grade 4 (stops for breath after walking about 100 meters or after a few minutes on the level)

or

Grade 5 (too breathless to leave the house, or breathless when dressing or undressing)

and

Actual FEV₁ (litres): < 0.6 x predicted (litres):

and

Patient is not a smoker (for reporting purposes only)

or

Patient is a smoker and has been offered smoking cessation counselling

and

The patient has been offered annual influenza immunisation

RENEWAL

Current approval Number (if known):

Applications only from a general practitioner or relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

Patient is compliant with the medication

and

Patient has experienced improved COPD symptom control (prescriber determined)

and

Applicant must state recent measurement of FEV₁ (% of predicted):

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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Sensory Organs

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:

Pilocarpine – Eye drops 2% single dose

INITIAL APPLICATION

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

Prerequisites (tick boxes where appropriate)

Patient has to use an unpreserved solution due to an allergy to the preservative

or

Patient wears soft contact lenses

Note:

Minims for a general practice are considered to be "tools of trade" and are not approved as special authority items.

RENEWAL

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

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

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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Post application to Ministry of Health, Private Bag 3015, Wanganui – Fax: 0800 100 131

Special Foods

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:

Carbohydrate (Moducal; Morrex Maltodextrin; Polycal; Polycose)

INITIAL APPLICATION - Cystic fibrosis or renal failure
Applications only from a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

- cystic fibrosis
or
 chronic renal failure or continuous ambulatory peritoneal dialysis (CAPD) patient

INITIAL APPLICATION - Indications other than cystic fibrosis or renal failure
Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- cancer in children
or
 cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years
or
 failure to thrive
or
 growth deficiency
or
 bronchopulmonary dysplasia
or
 premature and post premature infant
or
 inborn errors of metabolism

Use next page for: Renewal - Cystic fibrosis or renal failure and Renewal - Indications other than cystic fibrosis or renal failure
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

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:

Carbohydrate (Moducal; Morrex Maltodextrin; Polycal; Polycose) - continued

RENEWAL - Cystic fibrosis or renal failure

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

RENEWAL - Indications other than cystic fibrosis or renal failure

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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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:

Carbohydrate and Fat (Duocal Super Soluble Powder)

INITIAL APPLICATION - Cystic fibrosis
Applications only from a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

- infant aged four years or under
and
 cystic fibrosis

INITIAL APPLICATION - Indications other than cystic fibrosis
Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- infant aged four years or under
and
- cancer in children
 - or**
 - failure to thrive
 - or**
 - growth deficiency
 - or**
 - bronchopulmonary dysplasia
 - or**
 - premature and post premature infants

Use next page for: Renewal - Cystic fibrosis and Renewal - Indications other than cystic fibrosis

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

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:

Carbohydrate and Fat (Duocal Super Soluble Powder) - continued

RENEWAL - Cystic fibrosis

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

RENEWAL - Indications other than cystic fibrosis

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

Fat (Calogen; Liquigen; MCT oil (Nutricia))

INITIAL APPLICATION - Inborn errors of metabolism
Applications only from a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick box where appropriate)

The patient has inborn errors of metabolism

INITIAL APPLICATION - Indications other than inborn errors of metabolism
Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

failure to thrive where other high calorie products are inappropriate or inadequate

or

growth deficiency

or

bronchopulmonary dysplasia

or

fat malabsorption

or

lymphangiectasia

or

short bowel syndrome

or

infants with necrotising enterocolitis

or

biliary atresia

Use next page for: Renewal - Inborn errors of metabolism and Renewal - Indications other than inborn errors of metabolism

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

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:

Fat (Calogen; Liquigen; MCT oil (Nutricia)) - continued

RENEWAL - Inborn errors of metabolism

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

RENEWAL - Indications other than inborn errors of metabolism

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

Protein (Promod; Protifar 90)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

protein losing enteropathy

or

high protein needs (eg burns)

RENEWAL

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

Oral Supplements (Ensure; Nutridrink; Sustagen Hospital Formula)

INITIAL APPLICATION - Cystic fibrosis
Applications only from a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick box where appropriate)

The patient has cystic fibrosis

INITIAL APPLICATION - Indications other than cystic fibrosis
Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

cancer in children

or

inflammatory bowel disease

or

cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years

or

malnutrition requiring nutritional support

Use next page for: Renewal - Cystic fibrosis and Renewal - Indications other than cystic fibrosis

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

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:

Oral Supplements (Ensure; Nutridrink; Sustagen Hospital Formula) - continued

RENEWAL - Cystic fibrosis

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

RENEWAL - Indications other than cystic fibrosis

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

CORD Products (Pulmocare)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

CORD patients who have hypercapnia

and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

RENEWAL

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

Diabetic Products (Diasip; Diason; Glucerna; Glucerna RTH; Resource Diabetic; Resource Diabetic RTH)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

Type I and II diabetics who require nutritional supplementation
and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

RENEWAL

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment
and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

and
General Practitioners must include the name of the specialist and date contacted:

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

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:

Fat Modified Products (Monogen)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

The product is to be used as a complete diet

and

Patient has metabolic disorders of fat metabolism

or

Patient has chylothorax

RENEWAL

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

High Protein Products (Fortimel)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

Anorexia and weight loss

and

decompensating liver disease without encephalopathy

or

protein losing gastro-enteropathy

and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

RENEWAL

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

Paediatric Product For Children Awaiting Liver Transplant (Generaid Plus)

INITIAL APPLICATION

Applications only from a paediatrician. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

Child (up to 18 years) who is awaiting liver transplant

and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

RENEWAL

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

Applications only from a paediatrician. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

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

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:

Paediatric Product For Children With Chronic Renal Failure (Kindergen Plus)

INITIAL APPLICATION

Applications only from a paediatrician. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

child (up to 18 years) with chronic renal failure

and

The product is to be used as a supplement

or

The product is to be used as a complete diet

RENEWAL

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

Applications only from a paediatrician. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

The product is to be used as a supplement

or

The product is to be used as a complete diet

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

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:

Paediatric Products (Fortini; Fortini Multifibre; Nutrini Energy RTH; Nutrini RTH; Pediasure; Pediasure RTH; Resource Just for Kids)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

infant aged one to eight years

and

any condition causing malabsorption

or

failure to thrive

or

increased nutritional requirements

and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

RENEWAL

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

Renal Products (Nepro (vanilla); NovaSource Renal; Nutrison Concentrated RTH; Renilon 7.5)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

acute or chronic renal failure

and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

RENEWAL

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

Specialised And Elemental Products (Alitraq; Elemental 028 Extra; Peptisorb RTH; Vital HN; Vivonex TEN)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- malabsorption
- or
- short bowel syndrome
- or
- enterocutaneous fistulas
- or
- pancreatitis

and

- The product is to be used as a supplement (maximum 500 ml per day)
- or
- The product is to be used as a complete diet

Note:

Each of these products is highly specialised and would be prescribed only by an expert for a specific disorder. The alternative is hospitalisation.

Elemental 028 Extra is more expensive than other products listed in this section and should only be used where the alternatives have been tried first and/or are unsuitable.

RENEWAL

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

- The treatment remains appropriate and the patient is benefiting from treatment

and

- The product is to be used as a supplement (maximum 500 ml per day)
- or
- The product is to be used as a complete diet

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

Products for Undialysed End Stage Renal Failure (Suplena)

INITIAL APPLICATION

Applications only from a gastroenterologist or renal physician. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

undialysed end stage renal patients

and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

Note:

Where possible, the requirements for oral supplementation should be established in conjunction with assessment by a dietician.

RENEWAL

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

Adult Products Standard (Ensure Plus; Ensure Plus RTH; Fibresource; Fibresource RTH; Fortisip; Fortisip Multi Fibre; Isosource 1.5; Isosource Standard; Isosource Standard RTH; Jevity RTH; Nutrison Energy Multi Fibre; Nutrison Multi Fibre; Nutrison Standard RTH; Osmolite RTH; Resource Plus)

INITIAL APPLICATION - Oral feed for cystic fibrosis patient
Applications only from a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

Cystic fibrosis

and

The product is to be used as a supplement

or

The product is to be used as a complete diet

INITIAL APPLICATION - Oral feed for indications other than cystic fibrosis
Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

any condition causing malabsorption

or

failure to thrive

or

increased nutritional requirements

and

The product is to be used as a supplement

or

The product is to be used as a complete diet

RENEWAL - Oral feed cystic fibrosis patient

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

The product is to be used as a supplement

or

The product is to be used as a complete diet

and

General Practitioners must include the name of the specialist and date contacted:

Use next page for: Initial application - Enteral feed and Renewal - Enteral feed or Oral feed for indications other than cystic fibrosis

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

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:

Adult Products Standard (Ensure Plus; Ensure Plus RTH; Fibresource; Fibresource RTH; Fortisip; Fortisip Multi Fibre; Isosource 1.5; Isosource Standard; Isosource Standard RTH; Jevity RTH; Nutrison Energy Multi Fibre; Nutrison Multi Fibre; Nutrison Standard RTH; Osmolite RTH; Resource Plus) - continued

INITIAL APPLICATION - Enteral feed
Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

enteral feeding
or
 nasogastric
or
 nasoduodenal
or
 nasojejunal
or
 gastrostomy/jejunostomy

and

The product is to be used as a supplement
or
 The product is to be used as a complete diet

RENEWAL - Enteral feed or Oral feed for indications other than cystic fibrosis
Current approval Number (if known):.....

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

The product is to be used as a supplement
or
 The product is to be used as a complete diet

and
General Practitioners must include the name of the specialist and date contacted:

Note:
This group of products can be used either as a supplement or as a complete diet.
If a product is being used as a supplement, the limit is 500 ml per day.
Cystic fibrosis patients are exempt the 500 ml per day volume restriction when using Ensure Plus, Fortisip or Resource Plus as a supplement.

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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:

Adult Products High Calorie (Two Cal HN)

INITIAL APPLICATION - Cystic fibrosis

Applications only from a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

- Cystic fibrosis
- and
- other lower calorie products have been tried
- and
- patient has substantially increased metabolic requirements
- and
- The product is to be used as a supplement
- or
- The product is to be used as a complete diet

INITIAL APPLICATION - Indications other than cystic fibrosis

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- any condition causing malabsorption
- or
- failure to thrive
- or
- increased nutritional requirements
- and
- other lower calorie products have been tried
- and
- patient has substantially increased metabolic requirements
- and
- The product is to be used as a supplement
- or
- The product is to be used as a complete diet

Use next page for: Renewal - Cystic fibrosis and Renewal - Indications other than cystic fibrosis

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

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:

Adult Products High Calorie (Two Cal HN) - continued

RENEWAL - Cystic fibrosis

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

and

<input type="checkbox"/> The product is to be used as a supplement or <input type="checkbox"/> The product is to be used as a complete diet

RENEWAL - Indications other than cystic fibrosis

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

and

<input type="checkbox"/> The product is to be used as a supplement or <input type="checkbox"/> The product is to be used as a complete diet

Note:

This product can be used either as a supplement or as a complete diet.

If it is being used as a supplement, the limit is 500 ml per day.

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

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:

Food Thickeners (Karicare Food Thickener; Resource Thicken Up)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box where appropriate)

The patient has motor neurone disease with swallowing disorder

RENEWAL

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

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

**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:

Gluten Free Foods (Gluten Free Bread Mix 100% Bakels; Healtheries Wheat and Gluten Free Baking; Horleys Bread Mix; Horleys Flour; NZB Low Gluten Bread Mix; Orgran)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

Gluten enteropathy has been diagnosed by biopsy

or

Patient suffers from dermatitis herpetiformis

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

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:

Foods used for Homocystinuria or maple syrup urine disease (Maxamaid MSUD; Maxamum MSUD; MSUD Aid; XMET Maxamum)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

dietary management of homocystinuria

or

dietary management of maple syrup urine disease

RENEWAL

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

Foods used for PKU (Aminogran Food Supplement; Aminogran Mineral Mix; Analog LCP; Aprotin; Loprofin; Loprofin Mix; Maxamaid XP; Maxamum XP; Minaphlex; Phlexy 10)

INITIAL APPLICATION - Patient aged over 16

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

dietary management of PKU

and

The patient's blood phenylalanine level is: < 900 mmol/litre (average of tests over last 12 months)

INITIAL APPLICATION - Patient aged 16 or under

Applications only from a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick box where appropriate)

The patient requires dietary management of PKU

RENEWAL - Patient aged over 16

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

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

blood phenylalanine level: < 900 mmol/litre (average of tests over last 12 months)

RENEWAL - Patient aged 16 or under

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 3 years.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

Metabolic Mineral Mixture

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- Dietary management of phenylketonuria (PKU)
- or
- For use as a supplement to the ketogenic diet in patients diagnosed with epilepsy
- or
- Patient has had a previous approval for metabolic mineral mixture

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

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:

Infant Formulae – For Premature Infants (S26LBW; Similac Special Care)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

The patient is infant weighing less than 1.5 kg at birth

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

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:

Infant Formulae – For Williams Syndrome (Locasol)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box where appropriate)

The patient is an infant suffering from Williams Syndrome and associated hypercalcaemia

RENEWAL

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

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

**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:

Infant Formulae – For Gastrointestinal And Other Malabsorptive Problems (Neocate; Neocate Advance; Neocate LCP; Pepti Junior; Vivonex Pediatric)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box where appropriate)

The patient is infant suffering from malabsorption and other gastrointestinal problems

RENEWAL

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

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the specialist and date contacted:

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

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:

Infant Formulae – For Milk Intolerance (Delact; S26 Soy; Karicare Goats Milk Infant Formula)

INITIAL APPLICATION - Lactase deficiency or disaccharide intolerance

Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

Patient is less than 3 years of age

and

diagnosed as suffering from congenital lactase deficiency

or

suffering from disaccharide intolerance

Note:

Secondary lactose intolerance in children is usually short lasting, and can be controlled by dietary measures and by giving sufficient calories to regenerate digestive enzymes.

The subsidy for these products reflects the philosophy that the patient incurs no additional financial burden for purchasing specialised more expensive products.

INITIAL APPLICATION - Infant with intolerance to cows' milk

Applications only from a relevant specialist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

intolerant to cows' milk

and

patient is less than 3 years of age

Note:

The subsidy for these products reflects the philosophy that the patient incurs no additional financial burden for purchasing specialised more expensive products.

RENEWAL - Infant with intolerance to cows' milk

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

Applications only from a relevant specialist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

patient is less than 3 years of age

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

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:

Infant Formulae – Lactose Intolerance and Cows' Milk Protein Intolerance (Karicare All Ages)

INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

The patient is less than 2 years of age

and

Intolerant to cows' milk

and

Diagnosed as suffering from congenital lactase deficiency

RENEWAL

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

Applications only from a relevant specialist. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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

SA0053	Bee Venom Allergy Treatment; Wasp venom allergy treatment (Circle one)	121	SA0796	Ezetimibe	22
SA0090	Desmopressin – Inj 4 µg per ml, 1 ml	42	SA0826	Ezetimibe with Simvastatin (Vytorin)	24
SA0175	Cabergoline	43	SA0829	Adefovir dipivoxil	49
SA0256	Perhexiline Maleate	29	SA0831	Temozolomide	110
SA0291	Anti-inflammatory Non Steroidal Drugs (NSAIDs)	60	SA0832	Lamivudine	47
SA0312	Hormone Replacement Therapy – Systemic	38	SA0834	Insulin Glargine	7
SA0473	Imiglucerase	4	SA0835	Buserelin	40
SA0500	Combined oral contraceptives; Progestogen-only contraceptives (Circle one).....	35	SA0845	Enfuvirtide	54
SA0563	Octreotide (somatostatin analogue)	112	SA0855	Multiple Sclerosis Treatments	4
SA0581	Carbohydrate and Fat (Duocal Super Soluble Powder)	129	SA0863	Buspirone Hydrochloride	90
SA0582	Protein (Promod; Protifar 90)	133	SA0864	Mianserin Hydrochloride	74
SA0583	Oral Supplements (Ensure; Nutridrink; Sustagen Hospital Formula)	134	SA0866	Sirolimus (Rapamune)	119
SA0585	Adult Products High Calorie (Two Cal HN)	148	SA0867	Clopidogrel	16
SA0586	Products for Undialysed End Stage Renal Failure (Suplea)	145	SA0868	Etanercept	61
SA0587	Renal Products (Nepro (vanilla); NovaSource Renal; Nutrison Concentrated RTH; Renilon 7.5)	143	SA0869	Capecitabine	102
SA0588	CORD Products (Pulmocare)	136	SA0872	Tiotropium Bromide	123
SA0589	High Protein Products (Fortimel)	139	SA0877	Gemcitabine Hydrochloride	104
SA0592	Specialised And Elemental Products (Alitraq; Elemental Q28 Extra; Peptisorb RTH; Vital HN; Vivonex TEN)	144	SA0878	Irinotecan	103
SA0594	Diabetic Products (Diasip; Diason; Glucerna; Glucerna RTH; Resource Diabetic; Resource Diabetic RTH)	137	SA0879	Anagrelide Hydrochloride	108
SA0595	Food Thickeners (Karicare Food Thickener; Resource Thicken Up)	150	SA0880	Docetaxel	106
SA0601	Infant Formulae – For Williams Syndrome (Locasol)	156	SA0882	Thalidomide	109
SA0602	Infant Formulae – For Premature Infants (S26LBW; Similac Special Care)	155	SA0885	Trastuzumab	117
SA0603	Infant Formulae – For Gastrointestinal And Other Malabsorptive Problems (Neocate; Neocate Advance; Neocate LCP; Pepti Junior; Vivonex Pediatric)	157	SA0887	Ondansetron	83
SA0604	Infant Formulae – For Milk Intolerance (Delact; S26 Soy; Karicare Goats Milk Infant Formula)	158	SA0891	Macrogol 3350	11
SA0606	Paediatric Product For Children With Chronic Renal Failure (Kindergen Plus)	141	SA0895	Pilocarpine – Eye drops 2% single dose	125
SA0607	Paediatric Product For Children Awaiting Liver Transplant (Generaid Plus)	140	SA0896	Paediatric Products (Fortini; Fortini Multifibre; Nutri Energy RTH; Nutri RTH; Pediasure; Pediasure RTH; Resource Just for Kids)	142
SA0611	Dornase Alfa	4	SA0899	Fat (Calogen; Liquigen; MCT oil (Nutricia))	131
SA0615	Fat Modified Products (Monogen)	138	SA0900	Oxaliplatin	101
SA0643	Imatinib Mesylate	4	SA0901	Vinorelbine	105
SA0669	Tacrolimus	118	SA0906	Lignocaine with Prilocaine	72
SA0702	Adult Products Standard (Ensure Plus; Ensure Plus RTH; Fibresource; Fibresource RTH; Fortisip; Fortisip Multi Fibre; Isosource 1.5; Isosource Standard; Isosource Standard RTH; Jevity RTH; Nutrison Energy Multi Fibre; Nutrison Multi Fibre; Nutrison Standard RTH; Osmolite RTH; Resource Plus)	146	SA0907	Dexamphetamine Sulphate	91
SA0722	Gluten Free Foods (Gluten Free Bread Mix 100% Bakels; Healthies Wheat and Gluten Free Baking; Horleys Bread Mix; Horleys Flour; NZB Low Gluten Bread Mix; Orgran)	151	SA0908	Methylphenidate Hydrochloride (Rubifen; Rubifen SR; Ritalin; Ritalin SR)	94
SA0732	Foods used for Homocystinuria or maple syrup urine disease (Maxamaid MSUD; Maxamum MSUD; MSUD Aid; XMET Maxamum)	152	SA0909	Naltrexone	97
SA0733	Foods used for PKU (Aminogran Food Supplement; Aminogran Mineral Mix; Analog LCP; Aproten; Loprofin; Loprofin Mix; Maxamaid XP; Maxamum XP; Minaphlex; Phlexy 10)	153	SA0911	Losartan with or without hydrochlorothiazide	26
SA0739	Olanzapine wafers	89	SA0912	Carbohydrate (Moducal; Morrex Maltodextrin; Polycal; Polycose)	127
SA0741	Olanzapine tabs	85	SA0913	Budesonide – Cap 3 mg Controlled Release	6
SA0755	Growth Hormone Biosynthetic Human	4	SA0914	Ursodeoxycholic Acid – Cap 300 mg	10
SA0757	Infant Formulae – Lactose Intolerance and Cows' Milk Protein Intolerance (Karicare All Ages)	159	SA0915	Alpha Tocopheryl Acetate	12
SA0779	Antiretrovirals	52	SA0920	Aripiprazole	86
SA0782	Levonorgestrel – releasing intrauterine system 20µg/24 hr	39	SA0921	Levetiracetam	4
SA0784	Interferon Alpha-2A with ribavirin	58	SA0922	Erythropoietin	15
SA0788	Atorvastatin	20	SA0923	Imiquimod	33
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			SA0938	Domperidone	81
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			SA0949	Alendronate for Paget's Disease (Alendronate Tab 40 mg)	70
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			SA0962	Metabolic Mineral Mixture	154
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			SA0964	Azithromycin	45

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SA0969	liloprost	4
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