

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