Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0867
August 2010

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

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

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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.

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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.

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