

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 been treated with inhaled corticosteroids 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 been treated with inhaled corticosteroids 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: