

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:

Icatibant

Initial application

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

Prerequisites(tick boxes where appropriate)

- Supply for anticipated emergency treatment of laryngeal/oro-pharyngeal or severe abdominal attacks of acute hereditary angioedema (HAE) for patients with confirmed diagnosis of C1-esterase inhibitor deficiency
- and**
- The patient has undergone product training and has agreed upon an action plan for self-administration

Renewal

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

Applications from any relevant practitioner. Approvals valid for 12 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 – email: customerservice@health.govt.nz