

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Sacubitril with valsartan**

**Initial application**

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> Patient has heart failure
<b>and</b>
<input type="checkbox"/> Patient is in NYHA/WHO functional class II
<b>or</b>
<input type="checkbox"/> Patient is in NYHA/WHO functional class III
<b>or</b>
<input type="checkbox"/> Patient is in NYHA/WHO functional class IV
<b>and</b>
<input type="checkbox"/> Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 35%
<b>or</b>
<input type="checkbox"/> An ECHO is not reasonably practical, and in the opinion of the treating practitioner the patient would benefit from treatment
<b>and</b>
<input type="checkbox"/> Patient is receiving concomitant optimal standard chronic heart failure treatments

**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](mailto:customerservice@health.govt.nz)