

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:

Benzbromarone

Renewal

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

Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites(tick boxes where appropriate)

- | |
|---|
| <input type="checkbox"/> The treatment remains appropriate and the patient is benefitting from the treatment |
| and |
| <input type="checkbox"/> There is no evidence of liver toxicity and patient is continuing to receive regular (at least every three months) liver function tests |

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