

<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: .....

**Isotretinoin**

**Initial application**

Applications from any relevant practitioner. Approvals valid for 1 year.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Applicant is a vocationally registered dermatologist, vocationally registered general practitioner, or nurse practitioner working in a relevant scope of practice
<b>and</b>	
<input type="checkbox"/>	Applicant has an up to date knowledge of the safety issues around isotretinoin and is competent to prescribe isotretinoin
<b>and</b>	
<input type="checkbox"/>	Patient is of child bearing potential and the possibility of pregnancy has been excluded prior to commencement of treatment and patient has been counselled and understands the risk of teratogenicity if isotretinoin is used during pregnancy and that they must not become pregnant during treatment and for a period of one month after the completion of treatment
<b>or</b>	
<input type="checkbox"/>	Patient is not of child bearing potential

Note: Applicants are recommended to either have used or be familiar with using a decision support tool accredited by their professional body.

**Renewal**

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

Applications from any relevant practitioner. Approvals valid for 1 year.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient is of child bearing potential and the possibility of pregnancy has been excluded prior to commencement of treatment and patient has been counselled and understands the risk of teratogenicity if isotretinoin is used during pregnancy and that they must not become pregnant during treatment and for a period of one month after the completion of treatment
<b>or</b>	
<input type="checkbox"/>	Patient is not of child bearing potential

Note: Applicants are recommended to either have used or be familiar with using a decision support tool accredited by their professional body.

**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)