

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:

Sacubitril with valsartan

Initial application

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

Prerequisites(tick boxes where appropriate)

Patient has heart failure

and

Patient is in NYHA/WHO functional class II

or

Patient is in NYHA/WHO functional class III

or

Patient is in NYHA/WHO functional class IV

and

Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 35%

or

An ECHO is not reasonably practical, and in the opinion of the treating practitioner the patient would benefit from treatment

and

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