

<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: .....
.....	.....	.....
Fax Number: .....	Fax Number: .....	

### **Buprenorphine with naloxone**

#### **Initial application — Detoxification**

Applications from any medical practitioner. Approvals valid for 6 weeks.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> Patient is opioid dependent
<b>and</b>
<input type="checkbox"/> Patient is currently engaged with an opioid treatment service approved by the Ministry of Health
<b>and</b>
<input type="checkbox"/> Applicant works in an opioid treatment service approved by the Ministry of Health.

#### **Initial application — Maintenance treatment**

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> Patient is opioid dependent
<b>and</b>
<input type="checkbox"/> Patient will not be receiving methadone
<b>and</b>
<input type="checkbox"/> Patient is currently enrolled in an opioid substitution treatment program in a service approved by the Ministry of Health
<b>and</b>
<input type="checkbox"/> Applicant works in an opioid treatment service approved by the Ministry of Health

#### **Renewal — Detoxification**

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

Applications from any medical practitioner. Approvals valid for 6 weeks.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> Patient is opioid dependent
<b>and</b>
<input type="checkbox"/> Patient has previously trialled but failed detoxification with buprenorphine with naloxone with relapse back to opioid use and another attempt is planned
<b>and</b>
<input type="checkbox"/> Patient is currently engaged with an opioid treatment service approved by the Ministry of Health
<b>and</b>
<input type="checkbox"/> Applicant works in an opioid treatment service approved by the Ministry of Health

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)

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.....	.....	.....
Fax Number: .....	Fax Number: .....	

**Buprenorphine with naloxone** - *continued*

**Renewal — Maintenance treatment**

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

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient is or has been receiving maintenance therapy with buprenorphine with naloxone (and is not receiving methadone)	
<b>and</b>	<input type="checkbox"/>	Patient is currently enrolled in an opioid substitution program in a service approved by the Ministry of Health
<b>and</b>	<input type="checkbox"/>	Applicant works in an opioid treatment service approved by the Ministry of Health or is a medical practitioner authorised by the service to manage treatment in this patient

**Renewal — Maintenance treatment where the patient has previously had an initial application for detoxification**

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

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient received but failed detoxification with buprenorphine with naloxone	
<b>and</b>	<input type="checkbox"/>	Maintenance therapy with buprenorphine with naloxone is planned (and patient will not be receiving methadone)
<b>and</b>	<input type="checkbox"/>	Patient is currently enrolled in an opioid substitution program in a service approved by the Ministry of Health
<b>and</b>	<input type="checkbox"/>	Applicant works in an opioid treatment service approved by the Ministry of Health

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