

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:

Ferric carboxymaltose

Initial application — serum ferritin less than or equal to 20 mcg/L
Applications from any relevant practitioner. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

Patient has been diagnosed with iron-deficiency anaemia with a serum ferritin level of less than or equal to 20 mcg/L

and

Patient has been compliant with oral iron treatment and treatment has proven ineffective

or

Treatment with oral iron has resulted in dose-limiting intolerance

or

Rapid correction of anaemia is required

Renewal — serum ferritin less than or equal to 20 mcg/L
Current approval Number (if known):.....
Applications from any relevant practitioner. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

Patient continues to have iron-deficiency anaemia with a serum ferritin level of less than or equal to 20 mcg/L

and

A re-trial with oral iron is clinically inappropriate

Initial application — iron deficiency anaemia
Applications only from an internal medicine physician, obstetrician, gynaecologist, anaesthetist or medical practitioner on the recommendation of a internal medicine physician, obstetrician, gynaecologist or anaesthetist. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

Patient has been diagnosed with iron-deficiency anaemia

and

Patient has been compliant with oral iron treatment and treatment has proven ineffective

or

Treatment with oral iron has resulted in dose-limiting intolerance

or

Patient has symptomatic heart failure, chronic kidney disease stage 3 or more or active inflammatory bowel disease and a trial of oral iron is unlikely to be effective

or

Rapid correction of anaemia is required

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

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Address:	DOB:	Address:
.....	Address:
.....
Fax Number:	Fax Number:

Ferric carboxymaltose - *continued*

Renewal — iron deficiency anaemia

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

Applications only from an internal medicine physician, obstetrician, gynaecologist, anaesthetist or medical practitioner on the recommendation of a internal medicine physician, obstetrician, gynaecologist or anaesthetist. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

and	<input type="checkbox"/> Patient continues to have iron-deficiency anaemia
	<input type="checkbox"/> A re-trial with oral iron is clinically inappropriate

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

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