

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:

Clarithromycin

Initial application — Mycobacterial infections

Applications only from a respiratory specialist, infectious disease specialist or paediatrician. Approvals valid for 2 years.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Atypical mycobacterial infection
or
<input type="checkbox"/> Mycobacterium tuberculosis infection where there is drug-resistance or intolerance to standard pharmaceutical agents

Initial application — Helicobacter pylori eradication

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> For the eradication of helicobacter pylori in a patient unable to swallow tablets
and
<input type="checkbox"/> For use only in combination with omeprazole and amoxicillin as part of a triple therapy regimen

Initial application — Prophylaxis of infective endocarditis

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick box where appropriate)

<input type="checkbox"/> Prophylaxis of infective endocarditis associated with surgical or dental procedures if amoxicillin is contra-indicated

Renewal — Mycobacterial infections

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

Applications only from a respiratory specialist, infectious disease specialist or paediatrician. Approvals valid for 2 years.

Prerequisites(tick box where appropriate)

<input type="checkbox"/> 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