Enquiries to Ministry of Health 0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Acitretin		
Initial application Applications from any relevant practitioner. Approvals valid for 1 year. Prerequisites(tick boxes where appropriate) Applicant is a vocationally registered dermatologist, vocationally registered general practitioner, or nurse practitioner working in a relevant scope of practice and Applicant has an up to date knowledge of the safety issues around acitretin and is competent to prescribe acitretin and 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 acitretin is used during pregnancy and that they must not become pregnant during treatment and for a period of three years after the completion of treatment Patient is not of child bearing potential		
Renewal Current approval Number (if known):		
has been counselled and understa	and the possibility of pregnancy has been excluded and the risk of teratogenicity if acitretin is used during a period of three years after the completion of treatmential	pregnancy and that they must not become

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