

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER** Reg No: .....

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

.....      Address: .....      .....

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

**Long-Acting Muscarinic Antagonists with Long-Acting Beta-Adrenoceptor Agonists**

**Initial application**

Applications from any relevant practitioner. Approvals valid for 2 years.

**Prerequisites**(tick boxes where appropriate)

- Patient has been stabilised on a long acting muscarinic antagonist  
**and**  
 The prescriber considers that the patient would receive additional benefit from switching to a combination product

**Renewal**

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

Applications from any relevant practitioner. Approvals valid for 2 years.

**Prerequisites**(tick boxes where appropriate)

- Patient is compliant with the medication  
**and**  
 Patient has experienced improved COPD symptom control (prescriber determined)

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](mailto:customerservice@health.govt.nz)