

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:

Casirivimab and imdevimab

Initial application — Treatment of profoundly immunocompromised patients

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has confirmed (or probable) COVID-19
and	
<input type="checkbox"/>	The patient is in the community with mild to moderate disease severity*
and	
<input type="checkbox"/>	Patient is profoundly immunocompromised** and is at risk of not having mounted an adequate response to vaccination against COVID-19 or is unvaccinated
and	
<input type="checkbox"/>	Patient's symptoms started within the last 10 days
and	
<input type="checkbox"/>	Patient is not receiving high flow oxygen or assisted/mechanical ventilation
and	
<input type="checkbox"/>	Casirivimab and imdevimab is to be administered at a maximum dose of no greater than 2,400 mg

Note: * Mild to moderate disease severity as described on the [Ministry of Health Website](#)

** Examples include B-cell depletive illnesses or patients receiving treatment that is B-Cell depleting.

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