

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 — Anaemia

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

Prerequisites(tick boxes where appropriate)

Patient has been diagnosed with anaemia

and

Serum ferritin level is 20 mcg/L or less

or

Serum ferritin is between 20 and 50 mcg/L

and

C-Reactive Protein (CRP) is at least 5 mg/L

or

Patient has chronic inflammatory disease with symptoms of anaemia despite normal iron levels

and

Oral iron treatment has proven ineffective

or

Oral iron treatment has resulted in dose-limiting intolerance

or

Rapid correction of anaemia is required

Renewal — Anaemia

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

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

Prerequisites(tick boxes where appropriate)

Patient continues to have anaemia with a serum ferritin level of 20 mcg/L, or less or between 20 and 50 mcg/L with CRP of at least 5 mg/L, or has chronic inflammatory disease with symptoms of anaemia despite normal iron levels

and

A trial (or 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.

Signed: Date:

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz

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Ferric carboxymaltose - *continued*

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)

<input type="checkbox"/>	Patient has been diagnosed with iron-deficiency anaemia
and	
<input type="checkbox"/>	Patient has been compliant with oral iron treatment and treatment has proven ineffective
or	
<input type="checkbox"/>	Treatment with oral iron has resulted in dose-limiting intolerance
or	
<input type="checkbox"/>	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	
<input type="checkbox"/>	Rapid correction of anaemia is required

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)

<input type="checkbox"/>	Patient continues to have iron-deficiency anaemia
and	
<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.

Signed: Date:

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