

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Itraconazole**

**Initial application**

Applications only from an infectious disease specialist, clinical microbiologist, clinical immunologist or any relevant practitioner on the recommendation of a infectious disease physician, clinical microbiologist or clinical immunologist. Approvals valid for 6 months.

**Prerequisites**(tick box where appropriate)

The patient has a congenital immune deficiency

**Renewal**

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

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick box where appropriate)

The treatment remains appropriate and the patient is benefitting from the 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](mailto:customerservice@health.govt.nz)