

**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: .....

### Azithromycin

#### Initial application — bronchiolitis obliterans syndrome, cystic fibrosis and atypical Mycobacterium infections

Applications only from a relevant specialist. Approvals valid without further renewal unless notified.

**Prerequisites**(tick boxes where appropriate)

- Patient has received a lung transplant, stem cell transplant, or bone marrow transplant and requires treatment for bronchiolitis obliterans syndrome\*
- or
- Patient has received a lung transplant and requires prophylaxis for bronchiolitis obliterans syndrome\*
- or
- Patient has cystic fibrosis and has chronic infection with Pseudomonas aeruginosa or Pseudomonas-related gram negative organisms\*
- or
- Patient has an atypical Mycobacterium infection

Note: Indications marked with \* are unapproved indications.

#### Initial application — non-cystic fibrosis bronchiectasis\*

Applications only from a respiratory specialist or paediatrician. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- For prophylaxis of exacerbations of non-cystic fibrosis bronchiectasis\*
- and
- Patient is aged 18 and under
- and
- Patient has had 3 or more exacerbations of their bronchiectasis, within a 12 month period
- or
- Patient has had 3 acute admissions to hospital for treatment of infective respiratory exacerbations within a 12 month period

Note: Indications marked with \* are unapproved indications.

#### Renewal — non-cystic fibrosis bronchiectasis\*

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

Applications only from a respiratory specialist or paediatrician. Approvals valid for 12 months.

The patient must not have had more than 1 prior approval.

**Prerequisites**(tick boxes where appropriate)

- The patient has completed 12 months of azithromycin treatment for non-cystic fibrosis bronchiectasis
- and
- Following initial 12 months of treatment, the patient has not received any further azithromycin treatment for non-cystic fibrosis bronchiectasis for a further 12 months, unless considered clinically inappropriate to stop treatment
- and
- The patient will not receive more than a total of 24 months' azithromycin cumulative treatment (see note)

Note: No further renewals will be subsidised. A maximum of 24 months of azithromycin treatment for non-cystic fibrosis bronchiectasis will be subsidised. Indications marked with \* are unapproved indications

**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)