

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

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

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

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

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

**Aflibercept**

**Initial application — wet age related macular degeneration**

Applications only from an ophthalmologist. Approvals valid for 3 months.

**Prerequisites**(tick boxes where appropriate)

Wet age-related macular degeneration (wet AMD)

or

Polypoidal choroidal vasculopathy

or

Choroidal neovascular membrane from causes other than wet AMD

and

The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab

or

There is worsening of vision or failure of retina to dry despite three intravitreal injections of bevacizumab four weeks apart

and

There is no structural damage to the central fovea of the treated eye

and

Patient has not previously been treated with ranibizumab for longer than 3 months

or

Patient has current approval to use ranibizumab for treatment of wAMD and was found to be intolerant to ranibizumab within 3 months

or

Patient has previously\* (\*before June 2018) received treatment with ranibizumab for wAMD and disease was stable while on treatment

**Initial application — diabetic macular oedema**

Applications only from an ophthalmologist. Approvals valid for 4 months.

**Prerequisites**(tick boxes where appropriate)

Patient has centre involving diabetic macular oedema (DMO)

and

Patient's disease is non responsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly

and

Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision

and

Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers

and

There is no centre-involving sub-retinal fibrosis or foveal atrophy

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)

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**Aflibercept** - *continued*

**Renewal — wet age related macular degeneration**

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

Applications only from an ophthalmologist. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Documented benefit must be demonstrated to continue
<b>and</b>	
<input type="checkbox"/>	Patient's vision is 6/36 or better on the Snellen visual acuity score
<b>and</b>	
<input type="checkbox"/>	There is no structural damage to the central fovea of the treated eye

**Renewal — diabetic macular oedema**

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

Applications only from an ophthalmologist. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	There is stability or two lines of Snellen visual acuity gain
<b>and</b>	
<input type="checkbox"/>	There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid)
<b>and</b>	
<input type="checkbox"/>	Patient's vision is 6/36 or better on the Snellen visual acuity score
<b>and</b>	
<input type="checkbox"/>	There is no centre-involving sub-retinal fibrosis or foveal atrophy
<b>and</b>	
<input type="checkbox"/>	After each consecutive 12 months treatment with (2nd line anti-VEGF agent), patient has retrialled with at least one injection of bevacizumab and had no response

**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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