

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:

Dornase Alfa

Initial application — cystic fibrosis

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has a confirmed diagnosis of cystic fibrosis
and	
<input type="checkbox"/>	Patient has previously undergone a trial with, or is currently being treated with, hypertonic saline
and	
<input type="checkbox"/>	Patient has required one or more hospital inpatient respiratory admissions in the previous 12 month period
or	
<input type="checkbox"/>	Patient has had 3 exacerbations due to CF, requiring oral or intravenous (IV) antibiotics in the previous 12 month period
or	
<input type="checkbox"/>	Patient has had 1 exacerbation due to CF, requiring oral or IV antibiotics in the previous 12 month period and a Brasfield score of < 22/25
or	
<input type="checkbox"/>	Patient has a diagnosis of allergic bronchopulmonary aspergillosis (ABPA)

Renewal — cystic fibrosis

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

Applications only from a respiratory physician or paediatrician. Approvals valid without further renewal unless notified.

Prerequisites(tick box where appropriate)

The treatment remains appropriate and the patient continues to benefit from 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