

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:

Long-acting Somatostatin Analogues

Initial application — Malignant Bowel Obstruction

Applications from any relevant practitioner. Approvals valid for 2 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	The patient has nausea* and vomiting* due to malignant bowel obstruction*
and	
<input type="checkbox"/>	Treatment with antiemetics, rehydration, antimuscarinic agents, corticosteroids and analgesics for at least 48 hours has not been successful
and	
<input type="checkbox"/>	Treatment to be given for up to 4 weeks

Note: Indications marked with * are unapproved indications.

Renewal — Malignant Bowel Obstruction

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

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

Prerequisites(tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Initial application — Acromegaly

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	The patient has acromegaly
and	
<input type="checkbox"/>	Treatment with surgery and radiotherapy is not suitable or was unsuccessful
or	
<input type="checkbox"/>	Treatment is for an interim period while awaiting the beneficial effects of radiotherapy
and	
<input type="checkbox"/>	Treatment with a dopamine agonist has been unsuccessful

Renewal — Acromegaly

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

Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites(tick box where appropriate)

IGF1 levels have decreased since starting treatment

Note: In patients with acromegaly, treatment should be discontinued if IGF1 levels have not decreased 3 months after treatment. In patients treated with radiotherapy treatment should be withdrawn every 2 years, for 1 month, for assessment of remission. Treatment should be stopped where there is biochemical evidence of remission (normal IGF1 levels) following treatment withdrawal for at least 4 weeks

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

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:

Long-acting Somatostatin Analogues - continued

Initial application — pre-operative acromegaly

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Patient has acromegaly and <input type="checkbox"/> Patient has a large pituitary tumour, greater than 10 mm at its widest and <input type="checkbox"/> Patient is scheduled to undergo pituitary surgery in the next six months

Initial application — Other Indications

Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> VIPomas and Glucagonomas - for patients who are seriously ill in order to improve their clinical state prior to definitive surgery or	
<table border="1"> <tr> <td> <input type="checkbox"/> Gastrinoma and <input type="checkbox"/> Surgery has been unsuccessful or <input type="checkbox"/> Patient has metastatic disease after treatment with H2 antagonist or proton pump inhibitors has been unsuccessful </td> </tr> </table>	<input type="checkbox"/> Gastrinoma and <input type="checkbox"/> Surgery has been unsuccessful or <input type="checkbox"/> Patient has metastatic disease after treatment with H2 antagonist or proton pump inhibitors has been unsuccessful
<input type="checkbox"/> Gastrinoma and <input type="checkbox"/> Surgery has been unsuccessful or <input type="checkbox"/> Patient has metastatic disease after treatment with H2 antagonist or proton pump inhibitors has been unsuccessful	
or	
<table border="1"> <tr> <td> <input type="checkbox"/> Insulinomas and <input type="checkbox"/> Surgery is contraindicated or has not been successful </td> </tr> </table>	<input type="checkbox"/> Insulinomas and <input type="checkbox"/> Surgery is contraindicated or has not been successful
<input type="checkbox"/> Insulinomas and <input type="checkbox"/> Surgery is contraindicated or has not been successful	
or	
<input type="checkbox"/> For pre-operative control of hypoglycaemia and for maintenance therapy or	
<table border="1"> <tr> <td> <input type="checkbox"/> Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis) and <input type="checkbox"/> Disabling symptoms not controlled by maximal medical therapy </td> </tr> </table>	<input type="checkbox"/> Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis) and <input type="checkbox"/> Disabling symptoms not controlled by maximal medical therapy
<input type="checkbox"/> Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis) and <input type="checkbox"/> Disabling symptoms not controlled by maximal medical therapy	

Note: The use of a long-acting somatostatin analogue in patients with fistulae, oesophageal varices, miscellaneous diarrhoea and hypotension will not be funded under Special Authority

Renewal — Other Indications

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

Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites(tick box where appropriate)

The treatment remains appropriate and the patient is benefiting 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