

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 Muscarinic Antagonists with Long-Acting Beta-Adrenoceptor Agonists

Initial application

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

Prerequisites(tick boxes where appropriate)

- ☐ Patient has been stabilised on a long acting muscarinic antagonist
- and
- ☐ The prescriber considers that the patient would receive additional benefit from switching to a combination product

Renewal

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

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

Prerequisites(tick boxes where appropriate)

- ☐ Patient is compliant with the medication
- and
- ☐ Patient has experienced improved COPD symptom control (prescriber determined)

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