

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:

Emtricitabine with tenofovir disoproxil

Initial application

Applications from any relevant practitioner. Approvals valid for 24 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has tested HIV negative, does not have signs or symptoms of acute HIV infection and has been assessed for HIV seroconversion
and
☐ The Practitioner considers the patient is at elevated risk of HIV exposure and use of PrEP is clinically appropriate

Note: Refer to local health pathways or the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines:
<https://ashm.org.au/HIV/PrEP/>

Renewal

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

Applications from any relevant practitioner. Approvals valid for 24 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has tested HIV negative, does not have signs or symptoms of acute HIV infection and has been assessed for HIV seroconversion
and
☐ The Practitioner considers the patient is at elevated risk of HIV exposure and use of PrEP is clinically appropriate

Note: Refer to local health pathways or the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines:
<https://ashm.org.au/HIV/PrEP/>

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