

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

## Febuxostat

### Initial application — Gout

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has been diagnosed with gout
- and
- ☐ The patient has a serum urate level greater than 0.36 mmol/l despite treatment with allopurinol at doses of at least 600 mg/day and addition of probenecid at doses of up to 2 g per day or maximum tolerated dose
- or
- ☐ The patient has experienced intolerable side effects from allopurinol such that treatment discontinuation is required and serum urate remains greater than 0.36 mmol/l despite use of probenecid at doses of up to 2 g per day or maximum tolerated dose
- or
- ☐ The patient has renal impairment such that probenecid is contraindicated or likely to be ineffective and serum urate remains greater than 0.36 mmol/l despite optimal treatment with allopurinol (see Note)
- or
- ☐ The patient has previously had an initial Special Authority approval for benzbromarone for treatment of gout.

### Initial application — Tumour lysis syndrome

Applications only from a haematologist or oncologist. Approvals valid for 6 weeks.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient is scheduled to receive cancer therapy carrying an intermediate or high risk of tumour lysis syndrome
- and
- ☐ Patient has a documented history of allopurinol intolerance

### Renewal — Gout

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 benefitting from treatment

### Renewal — Tumour lysis syndrome

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

Applications only from a haematologist or oncologist. Approvals valid for 6 weeks.

**Prerequisites**(tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefitting 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](mailto:customerservice@health.govt.nz)