Enquiries to Ministry of Health 0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:	
Dexamethasone 700 mcg ocular impla	nts		
Initial application — Diabetic macular oedema Applications only from an ophthalmologist. Approv Prerequisites(tick boxes where appropriate)			
Patient has diabetic macular oedema with pseudophakic lens and Patient has reduced visual acuity of between 6/9 - 6/48 with functional awareness of reduction in vision and			
Patient's disease has progressed despite 3 injections with bevacizumab			
Patient is unsuitable or contraindicated to treatment with anti-VEGF agents			
Dexamethasone implants are to be 3 implants per eye per year	e administered not more frequently than once every 4	months into each eye, and up to a maximum of	
Renewal — Diabetic macular oedema			
Current approval Number (if known):			
Applications only from an ophthalmologist. Approv Prerequisites (tick boxes where appropriate)	rals valid for 12 months.		
Patient's vision is stable or has improved (prescriber determined) and			
Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year			
Initial application — Women of child bearing age with diabetic macular oedema Applications only from an ophthalmologist. Approvals valid for 12 months. Prerequisites(tick boxes where appropriate)			
Patient has diabetic macular oeder	та		
Patient has reduced visual acuity of between 6/9 - 6/48 with functional awareness of reduction in vision			
Patient is of child bearing potential and has not yet completed a family			
Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year			

I confirm the above details are correct and that in signing this form I understand I may be audited.

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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:	
Dexamethasone 700 mcg ocular impla	nts - continued		
Renewal — Women of child bearing age with diabetic macular oedema			
Current approval Number (if known):			
Applications only from an ophthalmologist. Approvals valid for 12 months.			
Prerequisites(tick boxes where appropriate)			
Patient's vision is stable or has improved (prescriber determined)			
Patient is of child bearing potential and has not yet completed a family			
	e administered not more frequently than once every 4	months into each eve. and up to a maximum of	

I confirm the above details are correct and that in signing this form I understand I may be audited.