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:
Lamivudine		
Initial application Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.  Prerequisites(tick box where appropriate)		
Used for the treatment or prevention of hepatitis B		
Renewal		
Current approval Number (if known):		
Applications from any relevant practitioner. Approvals valid for 2 years.  Prerequisites(tick box where appropriate)		
Used for the treatment or prevention of hepatitis B		

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