

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:

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
- 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