

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:

Palivizumab

Initial application

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

Prerequisites(tick boxes where appropriate)

☐	Palivizumab to be administered during the annual RSV season
and	
☐	Infant was born in the last 12 months
and	
☐	Infant was born at less than 32 weeks zero days' gestation
or	
☐	Child was born in the last 24 months
and	
☐	Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community
or	
☐	Child has haemodynamically significant heart disease
and	
☐	Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B)
or	
☐	Child has unoperated or surgically palliated complex congenital heart disease
or	
☐	Child has severe pulmonary hypertension (see Note C)
or	
☐	Child has moderate or severe left ventricular (LV) failure (see Note D)
or	
☐	Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant
or	
☐	Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist

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

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Palivizumab - continued

Renewal

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

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

Prerequisites(tick boxes where appropriate)

☐	Palivizumab to be administered during the annual RSV season
and	
☐	Child was born in the last 24 months
and	
☐	Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community
or	
☐	Child has haemodynamically significant heart disease
and	
☐	Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B)
or	
☐	Child has unoperated or surgically palliated complex congenital heart disease
or	
☐	Child has severe pulmonary hypertension (see Note C)
or	
☐	Child has moderate or severe left ventricular (LV) failure (see Note D)
or	
☐	Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant
or	
☐	Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist

Note:

- a) Ventilatory/respiratory support includes those on home oxygen, CPAP/VPAP and those with tracheostomies in situ managed at home
- b) Child requires/will require heart failure medication, and/or child has significant pulmonary hypertension, and/or infant will require surgical palliation/definitive repair within the next 3 months
- c) Mean pulmonary artery pressure more than 25 mmHg
- d) LV Ejection Fraction less than 40%
- e) Inborn errors of immunity include, but are not limited to, IFNAR deficiencies

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

Signed: Date:

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