

<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: .....

**Carbohydrate** (Moducal; Polycal)

**Initial application — Cystic fibrosis or kidney disease**

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

**Prerequisites**(tick boxes where appropriate)

- ☐ Cystic fibrosis  
or  
☐ Chronic kidney disease

**Initial application — Indications other than cystic fibrosis or renal failure**

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

**Prerequisites**(tick boxes where appropriate)

- ☐ Cancer in children  
or  
☐ Cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years  
or  
☐ Faltering growth in an infant/child  
or  
☐ Bronchopulmonary dysplasia  
or  
☐ Premature and post premature infant  
or  
☐ For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

**Initial application — Inborn errors of metabolism**

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified.

**Prerequisites**(tick box where appropriate)

- ☐ The patient has inborn errors of metabolism

**Renewal — Cystic fibrosis or renal failure**

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

**Prerequisites**(tick box, and write the data requested in the space provided where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment  
and  
General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted .....

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

Signed: ..... Date: .....

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)

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.....	Address: .....	.....
.....	.....	.....
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**Carbohydrate** (Moducal; Polycal) - *continued*

**Renewal — Indications other than cystic fibrosis or renal failure**

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

**Prerequisites**(tick box, and write the data requested in the space provided where appropriate)

<input type="checkbox"/> The treatment remains appropriate and the patient is benefiting from treatment <b>and</b> General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted .....
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