

<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: .....
.....	.....	.....
Fax Number: .....	Fax Number: .....	

### Icatibant

#### Initial application

Applications only from a clinical immunologist or relevant specialist. Approvals valid for 12 months.

#### Prerequisites (tick boxes where appropriate)

Supply for anticipated emergency treatment of laryngeal/oro-pharyngeal or severe abdominal attacks of acute hereditary angioedema (HAE) for patients with confirmed diagnosis of C1-esterase inhibitor deficiency  
and  
 The patient has undergone product training and has agreed upon an action plan for self-administration

#### Renewal

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

Applications from any relevant practitioner. Approvals valid for 12 months.

#### Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting 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 Health New Zealand, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)