

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:

MethylNaltrexone bromide

Initial application — Opioid induced constipation

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

The patient is receiving palliative care
and
 Oral and rectal treatments for opioid induced constipation are ineffective
or
 Oral and rectal treatments for opioid induced constipation are unable to be tolerated

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