

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:

Clarithromycin

Initial application — Mycobacterial infections

Applications only from a respiratory specialist, infectious disease specialist or paediatrician. Approvals valid for 2 years.

Prerequisites(tick boxes where appropriate)

or Atypical mycobacterial infection
 Mycobacterium tuberculosis infection where there is drug-resistance or intolerance to standard pharmaceutical agents

Initial application — Helicobacter pylori eradication

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

and For the eradication of helicobacter pylori in a patient unable to swallow tablets
 For use only in combination with omeprazole and amoxicillin as part of a triple therapy regimen

Initial application — Prophylaxis of infective endocarditis

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick box where appropriate)

Prophylaxis of infective endocarditis associated with surgical or dental procedures if amoxicillin is contra-indicated

Renewal — Mycobacterial infections

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

Applications only from a respiratory specialist, infectious disease specialist or paediatrician. Approvals valid for 2 years.

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