

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....
Fax Number:	Fax Number:	

Betaine

Initial application

Applications only from a metabolic physician. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

The patient has a confirmed diagnosis of homocystinuria
and

A cystathione beta-synthase (CBS) deficiency
or
 A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency
or
 A disorder of intracellular cobalamin metabolism

and

An appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation

Renewal

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

Applications only from a metabolic physician. 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