

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:	

Tacrolimus Ointment

Initial application

Applications only from a dermatologist, paediatrician or any relevant practitioner on the recommendation of a dermatologist, paediatrician, . Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

Patient has atopic dermatitis on the face
and
 Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy or documented allergy to topical corticosteroids

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