

**APPLICANT** (stamp or sticker acceptable)

Reg No: ..... First Names: ..... First Names: .....

Name: ..... Surname: ..... Surname: .....

Address: ..... DOB: ..... Address: .....

..... Address: .....

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

**Rosuvastatin**

**Initial application — cardiovascular disease risk**

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

**Prerequisites**(tick boxes where appropriate)

Patient is considered to be at risk of cardiovascular disease  
and  
 Patient is Māori or any Pacific ethnicity

or

Patient has a calculated risk of cardiovascular disease of at least 15% over 5 years  
and  
 LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin

**Initial application — familial hypercholesterolemia**

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

**Prerequisites**(tick boxes where appropriate)

Patient has familial hypercholesterolemia (defined as a Dutch Lipid Criteria score greater than or equal to 6)  
and  
 LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin

**Initial application — established cardiovascular disease**

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

**Prerequisites**(tick boxes where appropriate)

Patient has proven coronary artery disease (CAD)  
or  
 Patient has proven peripheral artery disease (PAD)  
or  
 Patient has experienced an ischaemic stroke

and

LDL cholesterol has not reduced to less than 1.4 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin

**Initial application — recurrent major cardiovascular events**

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

**Prerequisites**(tick boxes where appropriate)

Patient has experienced a recurrent major cardiovascular event (defined as myocardial infarction, ischaemic stroke, coronary revascularisation, hospitalisation for unstable angina) in the last 2 years  
and  
 LDL cholesterol has not reduced to less than 1.0 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin

**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)