

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:

Ivermectin

Initial application — Scabies

Applications from any relevant practitioner. Approvals valid for 1 month.

Prerequisites(tick boxes where appropriate)

or The person has a severe scabies hyperinfestation (Crusted/ Norwegian scabies)

and The person has a confirmed diagnosis of scabies or is a close contact of a scabies case

or The person is unable to complete topical therapy

or Previous treatment with topical therapy has been tried and not cleared the infestation

Initial application — Other parasitic infections

Applications from any relevant practitioner. Approvals valid for 1 month.

Prerequisites(tick boxes where appropriate)

or Filariasis

or Cutaneous larva migrans (creeping eruption)

or Strongyloidiasis

or The individual has a travel or residence history that requires presumptive parasite treatment

Renewal — Scabies

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

Applications from any relevant practitioner. Approvals valid for 1 month.

Prerequisites(tick boxes where appropriate)

or The person has a severe scabies hyperinfestation (Crusted/ Norwegian scabies)

and The person has a confirmed diagnosis of scabies or is a close contact of a scabies case

or The person is unable to complete topical therapy

or Previous treatment with topical therapy has been tried and not cleared the infestation

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

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Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....
Fax Number:	Fax Number:	

Ivermectin - continued

Renewal — Other parasitic infections

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

Applications from any relevant practitioner. Approvals valid for 1 month.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Filariasis
or
<input type="checkbox"/> Cutaneous larva migrans (creeping eruption)
or
<input type="checkbox"/> Strongyloidiasis

I confirm the above details are correct and that in signing this form I understand I may be audited.

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