

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:

Faricimab

Initial application — diabetic macular oedema

Applications from any relevant practitioner. Approvals valid for 4 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has centre involving diabetic macular oedema (DMO)	
and	<input type="checkbox"/>	Patient's disease is nonresponsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly
and	<input type="checkbox"/>	Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision
and	<input type="checkbox"/>	Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers
and	<input type="checkbox"/>	There is no centre-involving sub-retinal fibrosis or foveal atrophy
and	<input type="checkbox"/>	Patient has not previously been treated with aflibercept for longer than 3 months

Renewal — diabetic macular oedema

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	There is stability or two lines of Snellen visual acuity gain	
and	<input type="checkbox"/>	There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid)
and	<input type="checkbox"/>	Patient's vision is 6/36 or better on the Snellen visual acuity score
and	<input type="checkbox"/>	There is no centre-involving sub-retinal fibrosis or foveal atrophy

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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Faricimab - *continued*

Initial application — wet age related macular degeneration

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Wet age-related macular degeneration (wet AMD)
or
<input type="checkbox"/> Polypoidal choroidal vasculopathy
or
<input type="checkbox"/> Choroidal neovascular membrane from causes other than wet AMD

and

<input type="checkbox"/> The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab
or
<input type="checkbox"/> There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart

and

<input type="checkbox"/> There is no structural damage to the central fovea of the treated eye
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and

<input type="checkbox"/> Patient has not previously been treated with ranibizumab or aflibercept for longer than 3 months

Renewal — wet age related macular degeneration

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Patient's vision is 6/36 or better on the Snellen visual acuity score
and
<input type="checkbox"/> There is no structural damage to the central fovea of the treated eye

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

Signed: Date:

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