

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:

Lamivudine

Initial application

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

Prerequisites(tick box where appropriate)

Used for the treatment or prevention of hepatitis B

Renewal

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

Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites(tick box where appropriate)

Used for the treatment or prevention of hepatitis B

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