

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Dornase Alfa**

**Initial application — cystic fibrosis**

Applications only from a respiratory physician or paediatrician. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient has a confirmed diagnosis of cystic fibrosis
<b>and</b>	
<input type="checkbox"/>	Patient has previously undergone a trial with, or is currently being treated with, hypertonic saline
<b>and</b>	
<input type="checkbox"/>	Patient has required one or more hospital inpatient respiratory admissions in the previous 12 month period
<b>or</b>	
<input type="checkbox"/>	Patient has had 3 exacerbations due to CF, requiring oral or intravenous (IV) antibiotics in the previous 12 month period
<b>or</b>	
<input type="checkbox"/>	Patient has had 1 exacerbation due to CF, requiring oral or IV antibiotics in the previous 12 month period and a Brasfield score of < 22/25
<b>or</b>	
<input type="checkbox"/>	Patient has a diagnosis of allergic bronchopulmonary aspergillosis (ABPA)

**Renewal — cystic fibrosis**

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

Applications only from a respiratory physician or paediatrician. Approvals valid without further renewal unless notified.

**Prerequisites**(tick box where appropriate)

The treatment remains appropriate and the patient continues to benefit from treatment

**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)