

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER** Reg No: .....

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

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

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

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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)