

<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: .....

**Ivermectin**

**Initial application — Scabies**

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	The person has a severe scabies hyperinfestation (Crusted/ Norwegian scabies)
or	
<input type="checkbox"/>	The person has a confirmed diagnosis of scabies or is a close contact of a scabies case
and	
<input type="checkbox"/>	The person is unable to complete topical therapy
or	
<input type="checkbox"/>	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)

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

<input type="checkbox"/>	The person has a severe scabies hyperinfestation (Crusted/ Norwegian scabies)
or	
<input type="checkbox"/>	The person has a confirmed diagnosis of scabies or is a close contact of a scabies case
and	
<input type="checkbox"/>	The person is unable to complete topical therapy
or	
<input type="checkbox"/>	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](mailto:customerservice@health.govt.nz)

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