

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:

Tetracycline

Initial application
Applications from any relevant practitioner. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

For the eradication of helicobacter pylori following unsuccessful treatment with appropriate first-line therapy
and
 For use only in combination with bismuth as part of a quadruple therapy regimen

Renewal
Current approval Number (if known):.....
Applications from any relevant practitioner. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

For the eradication of helicobacter pylori following unsuccessful treatment with, or noncompletion of second line therapy
and
 For use only in combination with bismuth as part of a quadruple therapy regimen

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