

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:

Azithromycin

Initial application — bronchiolitis obliterans syndrome, cystic fibrosis and atypical Mycobacterium infections

Applications only from a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has received a lung transplant, stem cell transplant, or bone marrow transplant and requires treatment for bronchiolitis obliterans syndrome*
- or
- ☐ Patient has received a lung transplant and requires prophylaxis for bronchiolitis obliterans syndrome*
- or
- ☐ Patient has cystic fibrosis and has chronic infection with Pseudomonas aeruginosa or Pseudomonas-related gram negative organisms*
- or
- ☐ Patient has an atypical Mycobacterium infection

Note: Indications marked with * are unapproved indications.

Initial application — non-cystic fibrosis bronchiectasis*

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

Prerequisites(tick boxes where appropriate)

- ☐ For prophylaxis of exacerbations of non-cystic fibrosis bronchiectasis*
- and
- ☐ Patient is aged 18 and under
- and
- ☐ Patient has had 3 or more exacerbations of their bronchiectasis, within a 12 month period

or

☐ Patient has had 3 acute admissions to hospital for treatment of infective respiratory exacerbations within a 12 month period

Note: Indications marked with * are unapproved indications.

Renewal — non-cystic fibrosis bronchiectasis*

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

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

The patient must not have had more than 1 prior approval.

Prerequisites(tick boxes where appropriate)

- ☐ The patient has completed 12 months of azithromycin treatment for non-cystic fibrosis bronchiectasis
- and
- ☐ Following initial 12 months of treatment, the patient has not received any further azithromycin treatment for non-cystic fibrosis bronchiectasis for a further 12 months, unless considered clinically inappropriate to stop treatment
- and
- ☐ The patient will not receive more than a total of 24 months' azithromycin cumulative treatment (see note)

Note: No further renewals will be subsidised. A maximum of 24 months of azithromycin treatment for non-cystic fibrosis bronchiectasis will be subsidised. Indications marked with * are unapproved indications

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