

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:

Tolvaptan

Initial application — autosomal dominant polycystic kidney disease

Applications only from a renal physician or any relevant practitioner on the recommendation of a renal physician. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has a confirmed diagnosis of autosomal dominant polycystic kidney disease
- and
- ☐ Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 25 mL/min/1.73 m² at treatment initiation
- and
- ☐ Patient's disease is rapidly progressing, with a decline in eGFR of greater than or equal to 5 mL/min/1.73 m² within one-year

or

☐ Patient's disease is rapidly progressing, with an average decline in eGFR of greater than or equal to 2.5 mL/min/1.73 m² per year over a five-year period

Renewal — autosomal dominant polycystic kidney disease

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

Applications only from a renal physician or any relevant practitioner on the recommendation of a renal physician. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has not developed end-stage renal disease, defined as an eGFR of less than 15 mL/min/1.73 m²
- and
- ☐ Patient has not undergone a kidney transplant

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