

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:

Dexamethasone 700 mcg ocular implants

Initial application — Diabetic macular oedema
Applications only from an ophthalmologist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

Patient has diabetic macular oedema with pseudophakic lens
and Patient has reduced visual acuity of between 6/9 - 6/48 with functional awareness of reduction in vision
and

Patient's disease has progressed despite 3 injections with bevacizumab
or Patient is unsuitable or contraindicated to treatment with anti-VEGF agents

and Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year

Renewal — Diabetic macular oedema
Current approval Number (if known):.....
Applications only from an ophthalmologist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

Patient's vision is stable or has improved (prescriber determined)
and Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year

Initial application — Women of child bearing age with diabetic macular oedema
Applications only from an ophthalmologist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

Patient has diabetic macular oedema
and Patient has reduced visual acuity of between 6/9 - 6/48 with functional awareness of reduction in vision
and Patient is of child bearing potential and has not yet completed a family
and Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year

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

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Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....	Address:
.....
Fax Number:	Fax Number:

Dexamethasone 700 mcg ocular implants - *continued*

Renewal — Women of child bearing age with diabetic macular oedema

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

Applications only from an ophthalmologist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient's vision is stable or has improved (prescriber determined)
and	
<input type="checkbox"/>	Patient is of child bearing potential and has not yet completed a family
and	
<input type="checkbox"/>	Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year

I confirm the above details are correct and that in signing this form I understand I may be audited.

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