

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:

Fat (Calogen; Liquigen; MCT oil (Nutricia))

Initial application — Inborn errors of metabolism
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick box where appropriate)

The patient has an inborn error of metabolism

Initial application — Indications other than inborn errors of metabolism
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.
Prerequisites(tick boxes where appropriate)

Faltering growth in an infant/child
or
 Bronchopulmonary dysplasia
or
 Fat malabsorption
or
 Lymphangiectasia
or
 Short bowel syndrome
or
 Infants with necrotising enterocolitis
or
 Biliary atresia
or
 For use in a ketogenic diet
or
 Chyle leak
or
 Ascites
or
 For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

Renewal — Indications other than inborn errors of metabolism
Current approval Number (if known):.....

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.
Prerequisites(tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment
and
General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted

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