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|--|---------------------------|-------------------------------|
| 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: |

Fluconazole oral liquid

Initial application — Systemic candidiasis

Applications from any relevant practitioner. Approvals valid for 6 weeks.

Prerequisites(tick boxes where appropriate)

Patient requires prophylaxis for, or treatment of systemic candidiasis
and
 Patient is unable to swallow capsules

Initial application — Immunocompromised

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

Patient is immunocompromised
and
 Patient is at moderate to high risk of invasive fungal infection
and
 Patient is unable to swallow capsules

Renewal — Systemic candidiasis

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

Applications from any relevant practitioner. Approvals valid for 6 weeks.

Prerequisites(tick boxes where appropriate)

Patient requires prophylaxis for, or treatment of systemic candidiasis
and
 Patient is unable to swallow capsules

Renewal — Immunocompromised

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

Patient remains immunocompromised
and
 Patient remains at moderate to high risk of invasive fungal infection
and
 Patient is unable to swallow capsules

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