

**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: .....

**Methylnaltrexone bromide**

**Initial application — Opioid induced constipation**

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> The patient is receiving palliative care
<b>and</b>
<input type="checkbox"/> Oral and rectal treatments for opioid induced constipation are ineffective
<b>or</b>
<input type="checkbox"/> Oral and rectal treatments for opioid induced constipation are unable to be tolerated

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](mailto:customerservice@health.govt.nz)