

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:

Benzbromarone

Renewal

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

Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites(tick boxes where appropriate)

- | | |
|--|---|
| <input type="checkbox"/>

and
<input type="checkbox"/> | The treatment remains appropriate and the patient is benefitting from the treatment

There is no evidence of liver toxicity and patient is continuing to receive regular (at least every three months) liver function tests |
|--|---|

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