

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:

Tacrolimus Ointment

Initial application

Applications only from a dermatologist, paediatrician or any relevant practitioner on the recommendation of a dermatologist, paediatrician, . Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

<p><input type="checkbox"/> Patient has atopic dermatitis on the face</p> <p>and</p> <p><input type="checkbox"/> Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy or documented allergy to topical corticosteroids</p>
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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