

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:

Sacubitril with valsartan

Initial application

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Patient has heart failure
and
<input type="checkbox"/> Patient is in NYHA/WHO functional class II
or
<input type="checkbox"/> Patient is in NYHA/WHO functional class III
or
<input type="checkbox"/> Patient is in NYHA/WHO functional class IV
and
<input type="checkbox"/> Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 35%
or
<input type="checkbox"/> An ECHO is not reasonably practical, and in the opinion of the treating practitioner the patient would benefit from treatment
and
<input type="checkbox"/> Patient is receiving concomitant optimal standard chronic heart failure treatments

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