

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Ferric carboxymaltose**

**Initial application — Anaemia**

Applications from any relevant practitioner. Approvals valid for 3 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient has been diagnosed with anaemia
<b>and</b>	
<input type="checkbox"/>	Serum ferritin level is 20 mcg/L or less
<b>or</b>	
<input type="checkbox"/>	Serum ferritin is between 20 and 50 mcg/L
<b>and</b>	
<input type="checkbox"/>	C-Reactive Protein (CRP) is at least 5 mg/L
<b>or</b>	
<input type="checkbox"/>	Patient has chronic inflammatory disease with symptoms of anaemia despite normal iron levels
<b>and</b>	
<input type="checkbox"/>	Oral iron treatment has proven ineffective
<b>or</b>	
<input type="checkbox"/>	Oral iron treatment has resulted in dose-limiting intolerance
<b>or</b>	
<input type="checkbox"/>	Rapid correction of anaemia is required

**Renewal — Anaemia**

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

Applications from any relevant practitioner. Approvals valid for 3 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient continues to have anaemia with a serum ferritin level of 20 mcg/L, or less or between 20 and 50 mcg/L with CRP of at least 5 mg/L, or has chronic inflammatory disease with symptoms of anaemia despite normal iron levels
<b>and</b>	
<input type="checkbox"/>	A trial (or re-trial) with oral iron is clinically inappropriate

**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)

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.....	Address: .....	.....
.....	.....	.....
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**Ferric carboxymaltose** - *continued*

**Initial application — iron deficiency anaemia**

Applications only from an internal medicine physician, obstetrician, gynaecologist, anaesthetist or medical practitioner on the recommendation of a internal medicine physician, obstetrician, gynaecologist or anaesthetist. Approvals valid for 3 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient has been diagnosed with iron-deficiency anaemia
<b>and</b>	
<input type="checkbox"/>	Patient has been compliant with oral iron treatment and treatment has proven ineffective
<b>or</b>	
<input type="checkbox"/>	Treatment with oral iron has resulted in dose-limiting intolerance
<b>or</b>	
<input type="checkbox"/>	Patient has symptomatic heart failure, chronic kidney disease stage 3 or more or active inflammatory bowel disease and a trial of oral iron is unlikely to be effective
<b>or</b>	
<input type="checkbox"/>	Rapid correction of anaemia is required

**Renewal — iron deficiency anaemia**

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

Applications only from an internal medicine physician, obstetrician, gynaecologist, anaesthetist or medical practitioner on the recommendation of a internal medicine physician, obstetrician, gynaecologist or anaesthetist. Approvals valid for 3 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient continues to have iron-deficiency anaemia
<b>and</b>	
<input type="checkbox"/>	A re-trial with oral iron is clinically inappropriate

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

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