

| | | |
|--|---------------------------|-------------------------------|
| 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: |

Valganciclovir

Initial application — transplant cytomegalovirus prophylaxis

Applications only from a relevant specialist. Approvals valid for 3 months.

Prerequisites(tick box where appropriate)

The patient has undergone a solid organ transplant and requires valganciclovir for CMV prophylaxis

Renewal — transplant cytomegalovirus prophylaxis

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

Applications only from a relevant specialist. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

Patient has undergone a solid organ transplant and received anti-thymocyte globulin and requires valganciclovir therapy for CMV prophylaxis
and
 Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following anti-thymocyte globulin

or

Patient has received pulse methylprednisolone for acute rejection and requires further valganciclovir therapy for CMV prophylaxis
and
 Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following pulse methylprednisolone

Initial application — cytomegalovirus prophylaxis following anti-thymocyte globulin

Applications only from a relevant specialist. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

Patient has undergone a solid organ transplant and received valganciclovir under Special Authority more than 2 years ago (27 months)
and
 Patient has received anti-thymocyte globulin and requires valganciclovir for CMV prophylaxis

Renewal — cytomegalovirus prophylaxis following anti-thymocyte globulin

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

Applications only from a relevant specialist. Approvals valid for 3 months.

Prerequisites(tick box where appropriate)

The patient has received a further course of anti-thymocyte globulin and requires valganciclovir for CMV prophylaxis

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

| | | |
|--|---------------------------|-------------------------------|
| 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: |

Valganciclovir - continued

Initial application — Lung transplant cytomegalovirus prophylaxis

Applications only from a relevant specialist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Patient has undergone a lung transplant |
| and | |
| <input type="checkbox"/> | The donor was cytomegalovirus positive and the patient is cytomegalovirus negative |
| or | |
| <input type="checkbox"/> | The recipient is cytomegalovirus positive |
| and | |
| <input type="checkbox"/> | Patient has a high risk of CMV disease |

Renewal — Lung transplant cytomegalovirus prophylaxis

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

Applications only from a relevant specialist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Patient has undergone a lung re-transplant |
| and | |
| <input type="checkbox"/> | The donor was cytomegalovirus positive and the patient is cytomegalovirus negative |
| or | |
| <input type="checkbox"/> | The recipient is cytomegalovirus positive |
| and | |
| <input type="checkbox"/> | Patient has a high risk of CMV disease |

Initial application — Cytomegalovirus in immunocompromised patients

Applications only from a relevant specialist. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

| | |
|--------------------------|---|
| <input type="checkbox"/> | Patient is immunocompromised |
| and | |
| <input type="checkbox"/> | Patient has cytomegalovirus syndrome or tissue invasive disease |
| or | |
| <input type="checkbox"/> | Patient has rapidly rising plasma CMV DNA in absence of disease |
| or | |
| <input type="checkbox"/> | Patient has cytomegalovirus retinitis |

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

| | | |
|--|---------------------------|-------------------------------|
| 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: |

Valganciclovir - *continued*

Renewal — Cytomegalovirus in immunocompromised patients

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

Applications only from a relevant specialist. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

| | |
|--------------------------|---|
| <input type="checkbox"/> | Patient is immunocompromised |
| and | |
| <input type="checkbox"/> | Patient has cytomegalovirus syndrome or tissue invasive disease |
| or | |
| <input type="checkbox"/> | Patient has rapidly rising plasma CMV DNA in absence of disease |
| or | |
| <input type="checkbox"/> | Patient has cytomegalovirus retinitis |

Note: for the purpose of this Special Authority "immunocompromised" includes transplant recipients, patients with immunosuppressive diseases (e.g. HIV) or those receiving immunosuppressive treatment for other conditions.

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