

**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: .....

**Dexamethasone 700 mcg ocular implants**

**Initial application — Diabetic macular oedema**  
Applications only from an ophthalmologist. Approvals valid for 12 months.  
**Prerequisites**(tick boxes where appropriate)

Patient has diabetic macular oedema with pseudophakic lens  
**and**  Patient has reduced visual acuity of between 6/9 - 6/48 with functional awareness of reduction in vision  
**and**

Patient's disease has progressed despite 3 injections with bevacizumab  
**or**  Patient is unsuitable or contraindicated to treatment with anti-VEGF agents

**and**  Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year

**Renewal — Diabetic macular oedema**  
Current approval Number (if known):.....  
Applications only from an ophthalmologist. Approvals valid for 12 months.  
**Prerequisites**(tick boxes where appropriate)

Patient's vision is stable or has improved (prescriber determined)  
**and**  Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year

**Initial application — Women of child bearing age with diabetic macular oedema**  
Applications only from an ophthalmologist. Approvals valid for 12 months.  
**Prerequisites**(tick boxes where appropriate)

Patient has diabetic macular oedema  
**and**  Patient has reduced visual acuity of between 6/9 - 6/48 with functional awareness of reduction in vision  
**and**  Patient is of child bearing potential and has not yet completed a family  
**and**  Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year

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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|--|---------------------------|-------------------------------|
| <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: .....             |

**Dexamethasone 700 mcg ocular implants** - *continued*

**Renewal — Women of child bearing age with diabetic macular oedema**

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

Applications only from an ophthalmologist. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

|                          |  |
|--------------------------|--|
| <input type="checkbox"/> | Patient's vision is stable or has improved (prescriber determined)   |
| <b>and</b>               |  |
| <input type="checkbox"/> | Patient is of child bearing potential and has not yet completed a family   |
| <b>and</b>               |  |
| <input type="checkbox"/> | Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year |

**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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