

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:

Methylnaltrexone bromide

Initial application — Opioid induced constipation

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> The patient is receiving palliative care
and
<input type="checkbox"/> Oral and rectal treatments for opioid induced constipation are ineffective
or
<input type="checkbox"/> Oral and rectal treatments for opioid induced constipation are unable to be tolerated

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