

<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: .....

**Varenicline tartrate**

Note: a maximum of 12 weeks' varenicline will be subsidised on each Special Authority approval.  
This includes the 4-week 'starter' pack.

**Initial application**

Applications from any relevant practitioner. Approvals valid for 5 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking
<b>and</b>	<input type="checkbox"/>
	The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring
<b>and</b>	<input type="checkbox"/>
	The patient has tried but failed to quit smoking after at least two separate trials of nicotine replacement therapy, at least one of which included the patient receiving comprehensive advice on the optimal use of nicotine replacement therapy
<b>or</b>	<input type="checkbox"/>
	The patient has tried but failed to quit smoking using bupropion or nortriptyline
<b>and</b>	<input type="checkbox"/>
	The patient has not had a Special Authority for varenicline approved in the last 6 months
<b>and</b>	<input type="checkbox"/>
	Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this
<b>and</b>	<input type="checkbox"/>
	The patient is not pregnant
<b>and</b>	<input type="checkbox"/>
	The patient will not be prescribed more than 12 weeks' funded varenicline (see note)

**Renewal**

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

Applications from any relevant practitioner. Approvals valid for 5 months.

The patient must not have had an approval in the past 6 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking
<b>and</b>	<input type="checkbox"/>
	The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring
<b>and</b>	<input type="checkbox"/>
	It has been 6 months since the patient's previous Special Authority was approved
<b>and</b>	<input type="checkbox"/>
	Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this
<b>and</b>	<input type="checkbox"/>
	The patient is not pregnant
<b>and</b>	<input type="checkbox"/>
	The patient will not be prescribed more than 12 weeks' funded varenicline (see note)

**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)