

<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: .....

**Betaine**

**Initial application**  
Applications only from a metabolic physician. Approvals valid for 12 months.  
**Prerequisites**(tick boxes where appropriate)

The patient has a confirmed diagnosis of homocystinuria

and

A cystathionine beta-synthase (CBS) deficiency

or

A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency

or

A disorder of intracellular cobalamin metabolism

and

An appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation

**Renewal**  
Current approval Number (if known):.....  
Applications only from a metabolic physician. Approvals valid for 12 months.  
**Prerequisites**(tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

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)