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| 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: |

Sodium phenylbutyrate

Initial application

Applications only from a metabolic physician. Approvals valid for 12 months.

Prerequisites(tick box where appropriate)

The patient has a diagnosis of a urea cycle disorder involving a deficiency of carbamylphosphate synthetase, ornithine transcarbamylase or argininosuccinate synthetase

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