

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:

Pirfenidone

Initial application — idiopathic pulmonary fibrosis

Applications only from a respiratory specialist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist
and	
<input type="checkbox"/>	Forced vital capacity is between 50% and 90% predicted
and	
<input type="checkbox"/>	Pirfenidone is to be discontinued at disease progression (See Note)
and	
<input type="checkbox"/>	Pirfenidone is not to be used in combination with subsidised nintedanib
and	
<input type="checkbox"/>	The patient has not previously received treatment with nintedanib
or	
<input type="checkbox"/>	Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance
or	
<input type="checkbox"/>	Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib)

Renewal — idiopathic pulmonary fibrosis

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

Applications only from a respiratory specialist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment
and	
<input type="checkbox"/>	Pirfenidone is not to be used in combination with subsidised nintedanib
and	
<input type="checkbox"/>	Pirfenidone is to be discontinued at disease progression (See Note)

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

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