

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:

Fluticasone furoate with umeclidinium and vilanterol

Initial application

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has a diagnosis of COPD confirmed by spirometry or spirometry has been attempted and technically acceptable results are not possible
and	
<input type="checkbox"/>	Patient is currently receiving an inhaled corticosteroid with long acting beta-2 agonist (ICS/LABA) or a long acting muscarinic antagonist with long acting beta-2 agonist (LAMA/LABA)
and	
	Clinical criteria:
<input type="checkbox"/>	Patient has a COPD Assessment Test (CAT) score greater than 10
or	
<input type="checkbox"/>	Patient has had 2 or more exacerbations in the previous 12 months
or	
<input type="checkbox"/>	Patient has had one exacerbation requiring hospitalisation in the previous 12 months
or	
<input type="checkbox"/>	Patient has had an eosinophil count greater than or equal to 0.3×10^9 cells/L in the previous 12 months
or	
<input type="checkbox"/>	Patient is currently receiving multiple inhaler triple therapy (inhaled corticosteroid with long acting muscarinic antagonist and long acting beta-2 agonist – ICS/LAMA/LABA) and met at least one of the clinical criteria above prior to commencing multiple inhaler triple therapy

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