

<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: .....	.....
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Fax Number: .....	.....	Fax Number: .....

**Aflibercept**

**Initial application — diabetic macular oedema**

Applications from any relevant practitioner. Approvals valid for 4 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient has centre involving diabetic macular oedema (DMO)
<b>and</b>	
<input type="checkbox"/>	Patient's disease is non responsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly
<b>and</b>	
<input type="checkbox"/>	Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision
<b>and</b>	
<input type="checkbox"/>	Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers
<b>and</b>	
<input type="checkbox"/>	There is no centre-involving sub-retinal fibrosis or foveal atrophy
<b>and</b>	
<input type="checkbox"/>	Patient has not previously been treated with faricimab for longer than 3 months

**Renewal — diabetic macular oedema**

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

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	There is stability or two lines of Snellen visual acuity gain
<b>and</b>	
<input type="checkbox"/>	There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid)
<b>and</b>	
<input type="checkbox"/>	Patient's vision is 6/36 or better on the Snellen visual acuity score
<b>and</b>	
<input type="checkbox"/>	There is no centre-involving sub-retinal fibrosis or foveal atrophy

**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)

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Reg No: .....      First Names: .....      First Names: .....

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.....      Address: .....      .....

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Fax Number: .....      Fax Number: .....

**Aflibercept** - *continued*

**Initial application — wet age related macular degeneration**

Applications from any relevant practitioner. Approvals valid for 3 months.

**Prerequisites**(tick boxes where appropriate)

- Wet age-related macular degeneration (wet AMD)
- or
- Polypoidal choroidal vasculopathy
- or
- Choroidal neovascular membrane from causes other than wet AMD

and

- The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab
- or
- There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart

and

There is no structural damage to the central fovea of the treated eye

and

Patient has not previously been treated with ranibizumab or faricimab for longer than 3 months

or

- Patient has current approval to use ranibizumab or faricimab for treatment of wAMD and was found to be intolerant within 3 months
- or
- Patient has previously\* (\*before June 2018) received treatment with ranibizumab for wAMD and disease was stable while on treatment

**Renewal — wet age related macular degeneration**

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

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- Documented benefit must be demonstrated to continue
- and
- Patient's vision is 6/36 or better on the Snellen visual acuity score
- and
- There is no structural damage to the central fovea of the treated eye

I confirm the above details are correct and that in signing this form I understand I may be audited.

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