

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:

Letemovir

Initial application — CMV prophylaxis - post HSCT

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has undergone an allogeneic haematopoietic stem cell transplant
and	
<input type="checkbox"/>	The patient has confirmed presence of cytomegalovirus-specific antibodies
and	
<input type="checkbox"/>	Treatment to commence within 28 days of an allogeneic haematopoietic stem cell transplant
and	
<input type="checkbox"/>	Maximum treatment duration of 100 days post-transplant

Renewal — CMV prophylaxis – second or subsequent HSCT

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

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has undergone an allogeneic haematopoietic stem cell transplant
and	
<input type="checkbox"/>	The patient has confirmed presence of cytomegalovirus-specific antibodies
and	
<input type="checkbox"/>	Treatment to commence within 28 days of an allogeneic haematopoietic stem cell transplant
and	
<input type="checkbox"/>	Maximum treatment duration of 100 days post-transplant

Initial application — CMV prophylaxis - severe immunosuppression*

Applications only from an infectious disease specialist, clinical microbiologist or any relevant practitioner on the recommendation of a infectious disease specialist or clinical microbiologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has severe immunosuppression requiring prophylaxis of CMV
and	
<input type="checkbox"/>	Patient is contraindicated to all other funded CMV active oral antiviral agents
or	
<input type="checkbox"/>	Patient's CMV is resistant to all other funded CMV active oral antiviral agents

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

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Letemovir - *continued*

Renewal — CMV prophylaxis - severe immunosuppression*

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

Applications only from an infectious disease specialist, clinical microbiologist or any relevant practitioner on the recommendation of a infectious disease specialist or clinical microbiologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

and	<input type="checkbox"/> Patient has severe immunosuppression requiring prophylaxis of CMV
	or
	<input type="checkbox"/> Patient is contraindicated to all other funded CMV active oral antiviral agents
	<input type="checkbox"/> Patient's CMV is resistant to all other funded CMV active oral antiviral agents

Note: Indications marked with * are unapproved indications.

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

Signed: Date:

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