

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

**Palivizumab**

**Initial application**

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Palivizumab to be administered during the annual RSV season
<b>and</b>	
<input type="checkbox"/>	Infant was born in the last 12 months
<b>and</b>	
<input type="checkbox"/>	Infant was born at less than 32 weeks zero days' gestation
<b>and</b>	
<input type="checkbox"/>	Infant is to be administered palivizumab within a single calendar year
<b>or</b>	
<input type="checkbox"/>	Child was born in the last 24 months
<b>and</b>	
<input type="checkbox"/>	Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community
<b>or</b>	
<input type="checkbox"/>	Child has haemodynamically significant heart disease
<b>and</b>	
<input type="checkbox"/>	Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B)
<b>or</b>	
<input type="checkbox"/>	Child has unoperated or surgically palliated complex congenital heart disease
<b>or</b>	
<input type="checkbox"/>	Child has severe pulmonary hypertension (see Note C)
<b>or</b>	
<input type="checkbox"/>	Child has moderate or severe left ventricular (LV) failure (see Note D)
<b>or</b>	
<input type="checkbox"/>	Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant
<b>or</b>	
<input type="checkbox"/>	Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist

**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: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

.....      Address: .....      .....

.....      .....

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

**Palivizumab** - continued

**Renewal**

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

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

Palivizumab to be administered during the annual RSV season

**and**  Child was born in the last 24 months

**and**

Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community

**or**

Child has haemodynamically significant heart disease

**and**

Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B)

**or**  Child has unoperated or surgically palliated complex congenital heart disease

**or**  Child has severe pulmonary hypertension (see Note C)

**or**  Child has moderate or severe left ventricular (LV) failure (see Note D)

**or**

Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant

**or**

Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist

Note:

- a) Ventilatory/respiratory support includes those on home oxygen, CPAP/VPAP and those with tracheostomies in situ managed at home
- b) Child requires/will require heart failure medication, and/or child has significant pulmonary hypertension, and/or infant will require surgical palliation/definitive repair within the next 3 months
- c) Mean pulmonary artery pressure more than 25 mmHg
- d) LV Ejection Fraction less than 40%
- e) Inborn errors of immunity include, but are not limited to, IFNAR deficiencies

**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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