

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:

Fluconazole oral liquid

Initial application — Systemic candidiasis

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

Prerequisites(tick boxes where appropriate)

- ☐ Patient requires prophylaxis for, or treatment of systemic candidiasis
- and
- ☐ Patient is unable to swallow capsules

Initial application — Immunocompromised

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

Prerequisites(tick boxes where appropriate)

- ☐ Patient is immunocompromised
- and
- ☐ Patient is at moderate to high risk of invasive fungal infection
- and
- ☐ Patient is unable to swallow capsules

Renewal — Systemic candidiasis

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

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

Prerequisites(tick boxes where appropriate)

- ☐ Patient requires prophylaxis for, or treatment of systemic candidiasis
- and
- ☐ Patient is unable to swallow capsules

Renewal — Immunocompromised

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

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

Prerequisites(tick boxes where appropriate)

- ☐ Patient remains immunocompromised
- and
- ☐ Patient remains at moderate to high risk of invasive fungal infection
- and
- ☐ Patient is unable to swallow capsules

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