

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:

Fat (Calogen; Liquigen; MCT oil (Nutricia))

Initial application — Inborn errors of metabolism

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick box where appropriate)

☐ The patient has an inborn error of metabolism

Initial application — Indications other than inborn errors of metabolism

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites(tick boxes where appropriate)

- ☐ Faltering growth in an infant/child
- or
- ☐ Bronchopulmonary dysplasia
- or
- ☐ Fat malabsorption
- or
- ☐ Lymphangiectasia
- or
- ☐ Short bowel syndrome
- or
- ☐ Infants with necrotising enterocolitis
- or
- ☐ Biliary atresia
- or
- ☐ For use in a ketogenic diet
- or
- ☐ Chyle leak
- or
- ☐ Ascites
- or
- ☐ For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

Renewal — Indications other than inborn errors of metabolism

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites(tick box, and write the data requested in the space provided where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment
- and
- General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted

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