

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:

Sacubitril with valsartan

Initial application

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

☐ Patient has heart failure

and

☐ Patient is in NYHA/WHO functional class II

or

☐ Patient is in NYHA/WHO functional class III

or

☐ Patient is in NYHA/WHO functional class IV

and

☐ Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 35%

or

☐ An ECHO is not reasonably practical, and in the opinion of the treating practitioner the patient would benefit from treatment

and

☐ Patient is receiving concomitant optimal standard chronic heart failure treatments

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