

APPLICANT (stamp or sticker acceptable)

PATIENT NHI:

REFERRER Reg No:

Reg No:

First Names:

First Names:

Name:

Surname:

Surname:

Address:

DOB:

Address:

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Address:

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Aprepitant

Initial application

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

Prerequisites(tick box where appropriate)

☐ The patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy

Renewal

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

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

Prerequisites(tick box where appropriate)

☐ The patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy

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