

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**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: .....

## Dipyridamole Tab long-acting 150 mg

### INITIAL APPLICATION - Conditions other than transient ischaemic episodes

Applications only from a cardiothoracic surgeon, cardiologist or general physician. Approvals valid without further renewal unless notified.

#### Prerequisites (tick boxes where appropriate)

Patients with prosthetic heart valves – as an adjunct to oral anticoagulation for prophylaxis of thromboembolism

or

Patients after coronary artery vein bypass graft – as an adjunct to aspirin or as monotherapy for patients who are aspirin intolerant

#### Note:

Aspirin intolerant patients are defined as those with aspirin induced asthma, urticaria, or anaphylaxi, or those with significant aspirin induced bleeding, excluding bruising.

### INITIAL APPLICATION - Transient ischaemic episodes

Applications only from a neurologist, neuro surgeon, cardiologist, vascular surgeon or general physician. Approvals valid without further renewal unless notified.

#### Prerequisites (tick box where appropriate)

The patient continues to have transient ischaemic episodes despite aspirin therapy or has transient ischaemic episodes and is aspirin intolerant

#### Note:

Aspirin intolerant patients are defined as those with aspirin induced asthma, urticaria, or anaphylaxi, or those with significant aspirin induced bleeding, excluding bruising.

### RENEWAL - Existing 2 year approvals

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

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

#### Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: ..... Date: .....