

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:

Leflunomide

INITIAL APPLICATION

Applications only from a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- Rheumatoid arthritis
and
 Patient is not a pregnant woman, or a woman of child-bearing age without adequate contraception
and
 Patient has been unable to tolerate or has a contraindication to or has had an inadequate response to sulphasalazine and methotrexate (individually or in combination)

RENEWAL

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

Applications only from a rheumatologist. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- Compliance (prescriber determined) with medication
and
 Improved rheumatoid arthritis symptom control

Note:
Patient should have full blood count and liver function tests regularly monitored.

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

Signed: Date:

Post application to Ministry of Health, Private Bag 3015, Wanganui – Fax: 0800 100 131