

# 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: .....

## Perhexiline Maleate

### INITIAL APPLICATION

Applications only from a cardiologist or general physician. Approvals valid for 2 years.

**Prerequisites** (tick boxes where appropriate)

Refractory angina

and

Patient is already on maximal anti-anginal therapy

### RENEWAL

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

Applications only from a cardiologist or general physician. Approvals valid for 2 years.

**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: .....

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