

3 MEDICAL DETAILS (Prescribing doctor to complete in full)

Condition(s) to be authorised:

Patient co-morbidities:

1	PRODUCT NAME	STRENGTH	FORM	QUANTITY PER MONTH	START DATE	DURATION OF TREATMENT (MAX ONE YEAR) AND TERMINATION DATE	COST PER MONTH (SEP)	SCHEME TO COMPLETE	
								ACCEPTED/REJECTED	WHICH BENEFIT? PMB/CHRONIC/EX GRATIA
2									
3									
4									
5									
6									
7									

Motivation from prescribing doctor:

(Please attach the relevant test results.)

Previous medication used:

Relevant test results must be attached hereto:

(Please attach the relevant prescription.)