

**PBS/RPBS authority prescription**

Not valid unless authorized by delegate

Dr Mustafa Tahir Ali

MBBS, MPH

Silver Chain

Suite 7

197 Prospect Highway

SEVEN HILLS NSW 2147

Phone: 0416568644

2838171

01381803

Patient's Medicare no.

    -    -    Patient's Ref no.

Patient's full name

Nabiq Imdon

Patient's address

Tick for return to patient

Postcode

Entitlement no.

PBS Safety Net entitlement cardholder

Concessional or dependant, RPBS beneficiary or PBS Safety Net concession cardholder

**Authorisation is requested for the following:**

*(Tick appropriate boxes)*

PBS prescription from state manager, Medicare

RPBS prescription from the authorised delegate of the Repatriation Commission

Brand substitution not permitted

**Only one item per form**

ultrix benzofen  
110/80

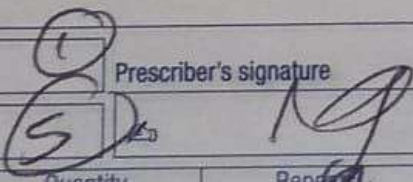
**Pharmacist/patient copy**

Dosage directions

Quantity

No. of repeats

Medicare/DVA use

Prescriber's signature 

Date

11/8/22

Quantity	Repeats	Phone/Delegate approval
5	1	FAC

*I declare that I have received this medicine and the information relating to any entitlement to a pharmaceutical benefit is correct.*

Patient's or agent's signature

Date of supply



1/1

Agent's address

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B025.2008

**Disease or purpose for which benefit required or clinical justification for use of item**

**PBS/RPBS authority prescription**

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Dr Mustafa Tahir Ali  
MBBS, MPH  
Silver Chain  
Suite 7  
197 Prospect Highway  
SEVEN HILLS NSW 2147  
Phone: 0416588644  
2838171

01381792

Patient's Medicare no.  -  -  Patient's Ref no.

Patient's full name

Patient's address

Tick for return to patient  Postcode

Entitlement no.

PBS Safety Net entitlement cardholder  Concessional or dependant, RPBS beneficiary or PBS Safety Net concession cardholder

**Authorisation is requested for the following:**

(Tick appropriate boxes)  
PBS prescription from state manager, Medicare   
RPBS prescription from the authorised delegate of the Repatriation Commission   
Brand substitution not permitted

**Only one item per form**

Symbicort  
1 x 30 200/16

Pharmacist/patient copy

Dosage directions

Quantity  Prescriber's signature  Date

No. of repeats

Medicare/DVA use	Quantity	Repeats	Phone/Delegate approval
			9904

I declare that I have received this medicine and the information relating to any entitlement to a pharmaceutical benefit is correct.

Patient's or agent's signature  Date of supply

Agent's address

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P8025.2008

**Disease or purpose for which benefit required or clinical justification for use of item**


Patient's age if under 18

Has the patient previously received an authority for this medicine? Yes  No

Prescriber's phone no.

Phone approvals – retain this copy for 12 months.  
Written approvals – forward all 3 copies to Medicare/DVA.

P8025.2008