

NAME: \_\_\_\_\_  
PRESCRIBER'S \_\_\_\_\_

00203550

**PBS/RPBS authority prescription**  
Not valid unless authorised by delegate

PRESCRIBER'S NAME: SARIMAN ARIF 06563237  
ADDRESS: 27/429 Peel St  
Manuka, 2840  
TELEPHONE: \_\_\_\_\_  
PRESCRIBER No: 2953207

Patient's Medicare no. 3137-95925-0 Patient's Ref no. 2  
Patient's full name NANCY de Vries  
Patient's address Manuka, 3820 VIC  
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**

LAGEXID 200mg

Pharmacist/patient copy  
Dosage directions 4 Capsule PO BID  
Quantity (40)  
No. of repeats \_\_\_\_\_  
Prescriber's signature \_\_\_\_\_ Date 5/11/22  
Medicare/DVA use \_\_\_\_\_ Quantity \_\_\_\_\_ Repeats \_\_\_\_\_ Phone/Delegate approval 13201

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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PB025.2008

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

For phone approvals call 1800 552 530 (all hours).  
Patient's age if under 18 \_\_\_\_\_