Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1125
October 2021

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: .....

Lacosamide

Initial application
Applications from any relevant practitioner. Approvals valid for 15 months.
Prerequisites(tick boxes where appropriate)

☐ Patient has partial-onset epilepsy

and

☐ Seizures are not adequately controlled by, or patient has experienced unacceptable side effects from, optimal treatment with all of the following: sodium valproate, topiramate, levetiracetam and any two of carbamazepine, lamotrigine and phenytoin sodium (see Note)

Note: "Optimal treatment" is defined as treatment which is indicated and clinically appropriate for the patient, given in adequate doses for the patient's age, weight and other features affecting the pharmacokinetics of the drug with good evidence of compliance. Women of childbearing age are not required to have a trial of sodium valproate.

Renewal

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

Applications from any relevant practitioner. Approvals valid for 24 months.
Prerequisites(tick box where appropriate)

☐ The patient has demonstrated a significant and sustained improvement in seizure rate or severity and/or quality of life compared with that prior to starting lacosamide treatment (see Note)

Note: As a guideline, clinical trials have referred to a notional 50% reduction in seizure frequency as an indicator of success with anticonvulsant therapy and have assessed quality of life from the patient's perspective.

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 – email: customerservice@health.govt.nz