

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:

Methylphenidate Hydrochloride Extended Release (Concerta; Ritalin LA)

Initial application

Applications only from a paediatrician, psychiatrist, medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing) or nurse practitioner on the recommendation of a paediatrician or psychiatrist (in writing). Approvals valid for 24 months.

Prerequisites(tick boxes where appropriate)

- ADHD (Attention Deficit and Hyperactivity Disorder)
and Diagnosed according to DSM-IV or ICD 10 criteria
and
- Applicant is a paediatrician or psychiatrist
or Applicant is a medical practitioner or nurse practitioner and confirms that a paediatrician or psychiatrist has been consulted within the last 2 years and has recommended treatment for the patient in writing
- and**
- Patient is taking a currently subsidised formulation of methylphenidate hydrochloride (immediate-release or sustained-release) which has not been effective due to significant administration and/or compliance difficulties
or There is significant concern regarding the risk of diversion or abuse of immediate-release methylphenidate hydrochloride

Renewal

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

Applications only from a paediatrician, psychiatrist, medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing) or nurse practitioner on the recommendation of a paediatrician or psychiatrist (in writing). Approvals valid for 24 months.

Prerequisites(tick boxes where appropriate)

- The treatment remains appropriate and the patient is benefiting from treatment
and
- Applicant is a paediatrician or psychiatrist
or Applicant is a medical practitioner or nurse practitioner and confirms that a paediatrician or psychiatrist has been consulted within the last 2 years and has recommended treatment for the patient in writing

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