

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:

Stiripentol

Initial application

Applications only from a paediatric neurologist or Practitioner on the recommendation of a paediatric neurologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

and	<input type="checkbox"/> Patient has confirmed diagnosis of Dravet syndrome
	<input type="checkbox"/> Seizures have been inadequately controlled by appropriate courses of sodium valproate, clobazam and at least two of the following: topiramate, levetiracetam, ketogenic diet

Renewal

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick box where appropriate)

The patient continues to benefit from treatment as measured by reduced seizure frequency from baseline

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