Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1125
March 2023

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: Patients of childbearing potential are not required to have a trial of sodium valporate

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

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