

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER** Reg No: .....

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

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Fax Number: .....      Fax Number: .....

**Melatonin**

**Initial application**

Applications only from a psychiatrist, paediatrician, neurologist, respiratory specialist or medical practitioner on the recommendation of a psychiatrist, paediatrician, neurologist or respiratory specialist. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

Patient has been diagnosed with persistent and distressing insomnia secondary to a neurodevelopmental disorder (including, but not limited to, autism spectrum disorder or attention deficit hyperactivity disorder)\*

**and**

Behavioural and environmental approaches have been tried and were unsuccessful, or are inappropriate

**and**

Funded modified-release melatonin is to be given at doses no greater than 10 mg per day

**and**

Patient is aged 18 years or under\*

**Renewal**

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

Applications only from a psychiatrist, paediatrician, neurologist, respiratory specialist or medical practitioner on the recommendation of a psychiatrist, paediatrician, neurologist or respiratory specialist. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

Patient is aged 18 years or under\*

**and**

Patient has demonstrated clinically meaningful benefit from funded modified-release melatonin (clinician determined)

**and**

Patient has had a trial of funded modified-release melatonin discontinuation within the past 12 months and has had a recurrence of persistent and distressing insomnia

**and**

Funded modified-release melatonin is to be given at doses no greater than 10 mg per day

Note: Indications marked with \* are unapproved indications.

**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](mailto:customerservice@health.govt.nz)