

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Aripiprazole**

**Initial application**

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> The patient has had an initial Special Authority approval for risperidone depot injection, paliperidone depot injection or olanzapine depot injection <b>or</b> <input type="checkbox"/> The patient has schizophrenia or other psychotic disorder <b>and</b> <input type="checkbox"/> The patient has received treatment with oral atypical antipsychotic agents but has been unable to adhere <b>and</b> <input type="checkbox"/> The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months
<b>or</b> <input type="checkbox"/> Patient has been unable to access olanzapine depot injection due to supply issues with olanzapine depot injection, or otherwise would have been started on olanzapine depot injection but has been unable to due to supply issues with olanzapine depot injection

Note: The Olanzapine depot injection Special Authority criteria that apply to criterion 2 in this Aripiprazole Special Authority application are as follows:

- The patient has had an initial Special Authority approval for paliperidone depot injection or risperidone depot injection; or
- All of the following:
  - The patient has schizophrenia; and
  - The patient has not been able to adhere with treatment using oral atypical antipsychotic agents; and
  - The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months.

**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)