Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Stiripentol

INITIATION

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- ❍ Prescribed by, or recommended by a paediatric neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ❍ Patient has confirmed diagnosis of Dravet syndrome

and

- ❍ Seizures have been inadequately controlled by appropriate courses of sodium valproate, clobazam and at least two of the following: topiramate, levetiracetam, ketogenic diet

Note: Those of childbearing potential are not required to trial sodium valproate or topiramate. Those who can father children are not required to trial sodium valproate.

CONTINUATION

Prerequisites (tick box where appropriate)

- ❍ Prescribed by, or recommended by a paediatric neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ❍ Patient continues to benefit from treatment as measured by reduced seizure frequency from baseline

I confirm that the above details are correct:

Signed: ..... Date: .....