## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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| Use this checklist to determine if a patient meets the restrictions for funding in the Schedule. For community funding, see the Special Authority Criteria.  | he <b>hospital setting</b> . For more details, refer to Section H of the Pharmaceutica   |
|--|--|
| PRESCRIBER   | PATIENT:   |
| Name:  | Name:  |
| Ward:  | NHI:   |
| Lacosamide   |  |
| INITIATION Re-assessment required after 15 months Prerequisites (tick boxes where appropriate)   |  |
| Patient has focal epilepsy and Seizures are not adequately controlled by, or patient has expe following: sodium valproate, topiramate, levetiracetam, and ar | erienced unacceptable side effects from, optimal treatment with all of the ny two of carbamazepine, lamotrigine, and phenytoin sodium (see Note) |
| Note: Those of childbearing potential are not required to trial phenytoin sodiur required to trial sodium valproate.   | m, sodium valproate, or topiramate. Those who can father children are not  |
| CONTINUATION Prerequisites (tick box where appropriate)  Patient has demonstrated a significant and sustained improvement i starting lacosamide treatment    | in seizure rate or severity and/or quality of life compared with that prior to   |
|  |  |

I confirm that the above details are correct:

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