PRESCRIBER	PATIENT:
Name:	Name:
Nard:	NHI:
acosamide	
INITIATION	
Re-assessment required after 15 months Prerequisites (tick boxes where appropriate)	
	has experienced unacceptable side effects from, optimal treatment with all of the m, and any two of carbamazepine, lamotrigine, and phenytoin sodium (see Note)
	oin sodium, sodium valproate, or topiramate. Those who can father children are not
CONTINUATION	
CONTINUATION Prerequisites (tick box where appropriate)	
 Patient has demonstrated a significant and sustained impro starting lacosamide treatment 	ovement in seizure rate or severity and/or quality of life compared with that prior to

I confirm that the above details are correct:

C:	D-1	
Signed.	Date:	
Oigilica.	 Duic.	