

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: .....

**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 experienced unacceptable side effects from, optimal treatment with all of the following: sodium valproate, topiramate, levetiracetam, and any two of carbamazepine, lamotrigine, and phenytoin sodium (see Note)

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

**CONTINUATION**

**Prerequisites** (tick box where appropriate)

- Patient has demonstrated a significant and sustained improvement in seizure rate or severity and/or quality of life compared with that prior to starting lacosamide treatment

I confirm that the above details are correct:

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