

<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: .....

**Riluzole**

**Initial application**

Applications only from a neurologist or respiratory specialist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	The patient has amyotrophic lateral sclerosis with disease duration of 5 years or less
<b>and</b>	
<input type="checkbox"/>	The patient has at least 60 percent of predicted forced vital capacity within 2 months prior to the initial application
<b>and</b>	
<input type="checkbox"/>	The patient has not undergone a tracheostomy
<b>and</b>	
<input type="checkbox"/>	The patient has not experienced respiratory failure
<b>and</b>	
<input type="checkbox"/>	The patient is ambulatory
<b>or</b>	
<input type="checkbox"/>	The patient is able to use upper limbs
<b>or</b>	
<input type="checkbox"/>	The patient is able to swallow

**Renewal**

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 18 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	The patient has not undergone a tracheostomy
<b>and</b>	
<input type="checkbox"/>	The patient has not experienced respiratory failure
<b>and</b>	
<input type="checkbox"/>	The patient is ambulatory
<b>or</b>	
<input type="checkbox"/>	The patient is able to use upper limbs
<b>or</b>	
<input type="checkbox"/>	The patient is able to swallow

**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)