

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT</b> NHI: .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
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Fax Number: .....	.....	Fax Number: .....

## Risdiplam

### Initial application — spinal muscular atrophy (SMA)

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation
- and
- ☐ Patient is 18 years of age or under
- and
- ☐ Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age
- or
- ☐ Patient is pre-symptomatic

and

☐ Patient has three or less copies of SMN2

### Renewal — spinal muscular atrophy (SMA)

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

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ There has been demonstrated maintenance of motor milestone function since treatment initiation
- and
- ☐ Patient does not require invasive permanent ventilation (at least 16 hours per day) in the absence of a potentially reversible cause while being treated with risdiplam
- and
- ☐ Risdiplam not to be administered in combination other SMA disease modifying treatments or gene therapy

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)