

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER 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)

- ☐ The patient has amyotrophic lateral sclerosis with disease duration of 5 years or less
- and
- ☐ The patient has at least 60 percent of predicted forced vital capacity within 2 months prior to the initial application
- and
- ☐ The patient has not undergone a tracheostomy
- and
- ☐ The patient has not experienced respiratory failure
- and
- ☐ The patient is ambulatory

or

☐ The patient is able to use upper limbs

or

☐ 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)

- ☐ The patient has not undergone a tracheostomy
- and
- ☐ The patient has not experienced respiratory failure
- and
- ☐ The patient is ambulatory

or

☐ The patient is able to use upper limbs

or

☐ 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 Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz