

**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: .....

### Vigabatrin

#### Initial application

Applications from any relevant practitioner. Approvals valid for 15 months.

**Prerequisites**(tick boxes where appropriate)

- Patient has infantile spasms
- or
- Patient has epilepsy
- and
- Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents
- or
- Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents

- or
- Patient has tuberous sclerosis complex

and

- Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter)
- or
- It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields.

#### Renewal

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

**Prerequisites**(tick boxes where appropriate)

- The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life
- and
- Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin
- or
- It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields.

**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](mailto:customerservice@health.govt.nz)