

<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: .....
.....	.....	.....
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  
or  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 Health New Zealand, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)