

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