

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER** Reg No: .....

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

.....      Address: .....      .....

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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)