

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:

Risdiplam

Initial application — spinal muscular atrophy (SMA)

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation
and	
<input type="checkbox"/>	Patient is 18 years of age or under
and	
<input type="checkbox"/>	Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age
or	
<input type="checkbox"/>	Patient is pre-symptomatic
and	
<input type="checkbox"/>	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)

<input type="checkbox"/>	There has been demonstrated maintenance of motor milestone function since treatment initiation
and	
<input type="checkbox"/>	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	
<input type="checkbox"/>	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