

<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: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Stiripentol**

**Initial application**

Applications only from a paediatric neurologist or Practitioner on the recommendation of a paediatric neurologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> Patient has confirmed diagnosis of Dravet syndrome <b>and</b> <input type="checkbox"/> Seizures have been inadequately controlled by appropriate courses of sodium valproate, clobazam and at least two of the following: topiramate, levetiracetam, ketogenic diet
---

Note: Those of childbearing potential are not required to trial sodium valproate or topiramate. Those who can father children are not required to trial sodium valproate.

**Renewal**

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

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

**Prerequisites**(tick box where appropriate)

The patient continues to benefit from treatment as measured by reduced seizure frequency from baseline

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)