

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:

Modafinil

Initial application

Applications only from a neurologist or respiratory specialist. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

The patient has a diagnosis of narcolepsy and has excessive daytime sleepiness associated with narcolepsy occurring almost daily for three months or more

and

The patient has a multiple sleep latency test with a mean sleep latency of less than or equal to 10 minutes and 2 or more sleep onset rapid eye movement periods

or

The patient has at least one of: cataplexy, sleep paralysis or hypnagogic hallucinations

and

An effective dose of a subsidised formulation of methylphenidate or dexamfetamine has been trialled and discontinued because of intolerable side effects

or

Methylphenidate and dexamfetamine are contraindicated

or

Patient meets the Special Authority criteria for methylphenidate hydrochloride or methylphenidate hydrochloride extended-release for narcolepsy

and

Patient is unable to access methylphenidate hydrochloride presentations due to an out of stock (see note)

Note: Criterion 2 is to permit short-term funding to cover an out-of-stock of methylphenidate hydrochloride or methylphenidate hydrochloride extended release.

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