

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:

Olanzapine depot injection

Initial application

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

Prerequisites(tick boxes where appropriate)

The patient has had an initial Special Authority approval for paliperidone depot injection or risperidone depot injection

or

The patient has schizophrenia or other psychotic disorder

and

The patient has tried but failed to comply with treatment using oral atypical antipsychotic agents

and

The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months

and

The patient has trialed other funded depot antipsychotics (aripiprazole, risperidone, and paliperidone) unless it is considered clinically inappropriate to use these

and

The patient continues to have difficulties with adherence on oral antipsychotic treatments

and

Prescribing clinician has relevant Clinical Director (Mental Health and Addiction services) approval

Renewal

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

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

Prerequisites(tick box where appropriate)

The initiation of olanzapine depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection

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