

<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: .....

**Olanzapine depot injection**

**Initial application**

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> The patient has had an initial Special Authority approval for paliperidone depot injection or risperidone depot injection <b>or</b> <input type="checkbox"/> The patient has schizophrenia or other psychotic disorder <b>and</b> <input type="checkbox"/> The patient has tried but failed to comply with treatment using oral atypical antipsychotic agents <b>and</b> <input type="checkbox"/> 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 <b>and</b> <input type="checkbox"/> The patient has trialed other funded depot antipsychotics (aripiprazole, risperidone, and paliperidone) unless it is considered clinically inappropriate to use these <b>and</b> <input type="checkbox"/> The patient continues to have difficulties with adherence on oral antipsychotic treatments <b>and</b> <input type="checkbox"/> Prescribing clinician has relevant Clinical Director (Mental Health and Addiction services) approval
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**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](mailto:customerservice@health.govt.nz)