

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