

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)

<input type="checkbox"/>	The patient has a diagnosis of narcolepsy and has excessive daytime sleepiness associated with narcolepsy occurring almost daily for three months or more
and	
<input type="checkbox"/>	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
<input type="checkbox"/>	The patient has at least one of: cataplexy, sleep paralysis or hypnagogic hallucinations
and	
<input type="checkbox"/>	An effective dose of a subsidised formulation of methylphenidate or dexamfetamine has been trialled and discontinued because of intolerable side effects
<input type="checkbox"/>	Methylphenidate and dexamfetamine are contraindicated
or	
<input type="checkbox"/>	Patient meets the Special Authority criteria for methylphenidate hydrochloride or methylphenidate hydrochloride extended-release for narcolepsy
<input type="checkbox"/>	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