

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:

Vigabatrin

Initial application

Applications from any relevant practitioner. Approvals valid for 15 months.

Prerequisites(tick boxes where appropriate)

☐ Patient has infantile spasms

or

☐ Patient has epilepsy

and

☐ Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents

or

☐ Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents

or

☐ Patient has tuberous sclerosis complex

and

☐ Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter)

or

☐ It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields.

Renewal

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

☐ The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life

and

☐ Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin

or

☐ It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields.

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