

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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:

Methylphenidate Hydrochloride Extended Release (Concerta; Ritalin LA)

INITIAL APPLICATION

Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

ADHD (Attention Deficit and Hyperactivity Disorder)

and

Diagnosed according to DSM-IV or ICD 10 criteria

and

Applicant is a paediatrician or psychiatrist

or

Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

and

Provide name of the recommending specialist:

and

Patient is taking a currently subsidised formulation of methylphenidate hydrochloride (immediate-release or sustained-release) which has not been effective due to significant administration and/or compliance difficulties

or

There is significant concern regarding the risk of diversion or abuse of immediate-release methylphenidate hydrochloride

RENEWAL

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

Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

and

Applicant is a paediatrician or psychiatrist

or

Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

and

Provide name of the recommending specialist:

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

Post application to Ministry of Health, Private Bag 3015, Wanganui – Fax: 0800 100 131