

Request Form for rufinamide [Banzel®]

Physician Information

Name: _____

License: _____ Physician specialty: _____

Address: _____

Telephone: _____ Fax: _____

Patient Information

General Information

Name: _____ Date of Birth: _____

Sex: M F Weight (kg): _____ Member ID: _____

Address: _____

Medical Information

1) Does the patient present Lennox-Gastaut Syndrome? Yes No

2) How old is the patient? _____

3) Does the patient have Familial Short QT Syndrome? Yes No

Please provide any medical information which may support approval: (optional)

Physician signature:

Date: