HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Riluzole

INITIATION
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Te Whatu Ora Hospital.

and

- ○ The patient has amyotrophic lateral sclerosis with disease duration of 5 years or less

and

- ○ The patient has at least 60 percent of predicted forced vital capacity within 2 months prior to the initial application

and

- ○ The patient has not undergone a tracheostomy

and

- ○ The patient has not experienced respiratory failure

and

- ○ The patient is ambulatory

or

- ○ The patient is able to use upper limbs

or

- ○ The patient is able to swallow

CONTINUATION
Re-assessment required after 18 months
Prerequisites (tick boxes where appropriate)

- ○ The patient has not undergone a tracheostomy

and

- ○ The patient has not experienced respiratory failure

and

- ○ The patient is ambulatory

or

- ○ The patient is able to use upper limbs

or

- ○ The patient is able to swallow

I confirm that the above details are correct:

Signed: ..... Date: .....