Form RS1794
June 2024

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: ....

Betaine

INITIATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ◯ Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ◯ The patient has a confirmed diagnosis of homocystinuria

  and

  - ◯ A cystathionine beta-synthase (CBS) deficiency

    or
  - ◯ A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency

    or
  - ◯ A disorder of intracellular cobalamin metabolism

  and
- ◯ An appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation

CONTINUATION
Re-assessment required after 12 months
Prerequisites (tick box where appropriate)

- ◯ Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ◯ The treatment remains appropriate and the patient is benefiting from treatment

HOSPITAL

I confirm that the above details are correct:

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