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: .....

Dexamphetamine sulphate

INITIATION – ADHD

Prerequisites (tick box where appropriate)

- ❍ Prescribed by, or recommended by a paediatrician or psychiatrist, or in accordance with a protocol or guideline that has been endorsed by the Te Whatu Ora Hospital.

and

- ❍ Patient has ADHD (Attention Deficit and Hyperactivity Disorder), diagnosed according to DSM-IV or ICD 10 criteria

INITIATION – Narcolepsy

Re-assessment required after 24 months

Prerequisites (tick box 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

- ❍ Patient suffers from narcolepsy

CONTINUATION – Narcolepsy

Re-assessment required after 24 months

Prerequisites (tick box 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 treatment remains appropriate and the patient is benefiting from treatment

HOSPITAL

I confirm that the above details are correct:

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