

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

I confirm that the above details are correct:

Signed: Date: