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: $\qquad$

## PATIENT:

Name: $\qquad$

Ward: NH: $\qquad$

## 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 Te Whatu Ora Hospital.
and
The patient has a confirmed diagnosis of homocystinuria
andA disorder of intracellular cobalamin metabolism andAn 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 Te Whatu Ora Hospital.
and
The treatment remains appropriate and the patient is benefiting from treatment

I confirm that the above details are correct:
$\qquad$
$\qquad$

