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: .....

Sodium phenylbutyrate

INITIATION
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

- ◯ For the chronic management of a urea cycle disorder involving a deficiency of carbamylphosphate synthetase, ornithine transcarbamylase or argininosuccinate synthetase

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: .....