## 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.

PRES	CRIBER	PATIENT:	
Name	:	Name:	
Ward:		NHI:	
Taur	ine		
Re-a	ATION ssessment required after 6 months equisites (tick box where appropriate)  Prescribed by, or recommended by a metabolic physician, or in accommodate NZ Hospital.  The patient has a suspected specific mitochondrial disorder that materials.	ordance with a protocol or guideline that has been endorsed by the Health y respond to taurine supplementation	
CONTINUATION Re-assessment required after 24 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			
	O The patient has a confirmed diagnosis of a specific mitochond and The treatment remains appropriate and the patient is benefiting		

I confirm that the above details are correct:		
Signed:	Date:	