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: .....

Tacrolimus

INITIATION – organ transplant recipients

Prerequisites (tick box where appropriate)

- ○ Prescribed by, or recommended by any specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ For use in organ transplant recipients

INITIATION – non-transplant indications*

Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by any specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ Patient requires long-term systemic immunosuppression

and

- ○ Ciclosporin has been trialled and discontinued treatment because of unacceptable side effects or inadequate clinical response

or

- ○ Patient is a child with nephrotic syndrome*

Note: Indications marked with * are unapproved indications

I confirm that the above details are correct:

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