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.

g, and appears a second process.		
PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Methylphenidate hydrochloride		
INITIATION – ADHD (immediate-release and sustained-release formulation in Prerequisites (tick box where appropriate)	ons)	
O Prescribed by, or recommended by a paediatrician or psychiatrist, or Health NZ Hospital.	in accordance with a protocol or guideline that has been endorsed by the	
Patient has ADHD (Attention Deficit and Hyperactivity Disorder), diag	gnosed according to DSM-IV or ICD 10 criteria	
INITIATION – Narcolepsy (immediate-release and sustained-release formulations) Prerequisites (tick box where appropriate) Prescribed by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
O Patient suffers from narcolepsy		
Health NZ Hospital. Patient has ADHD (Attention Deficit and Hyperactivity Disorde and Patient is taking a currently listed formulation of methylp has not been effective due to significant administration a	henidate hydrochloride (immediate-release or sustained-release) which	
INITIATION – Narcolepsy* (extended-release only) Prerequisites (tick box where appropriate)		
Prescribed by, or recommended by a neurologist or respiratory spec by the Health NZ Hospital. and Patient suffers from narcolepsy Note: *narcolepsy is not a registered indication for Concerta, Ritalin LA or Me	ialist, or in accordance with a protocol or guideline that has been endorsed thylphenidate Sandoz XR.	

I confirm that the above details are correct:

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	