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: .....

Melatonin

INITIATION – insomnia secondary to neurodevelopmental disorder
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

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

and

- ○ Patient has been diagnosed with persistent and distressing insomnia secondary to a neurodevelopmental disorder (including, but not limited to, autism spectrum disorder or attention deficit hyperactivity disorder)

and

- ○ Behavioural and environmental approaches have been tried or are inappropriate

and

- ○ Funded modified-release melatonin is to be given at doses no greater than 10 mg per day

and

- ○ Patient is aged 18 years or under

CONTINUATION – insomnia secondary to neurodevelopmental disorder
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

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

and

- ○ Patient is aged 18 years or under

and

- ○ Patient has demonstrated clinically meaningful benefit from funded modified-release melatonin (clinician determined)

and

- ○ Patient has had a trial of funded modified-release melatonin discontinuation within the past 12 months and has had a recurrence of persistent and distressing insomnia

and

- ○ Funded modified-release melatonin is to be given at doses no greater than 10 mg per day

INITIATION – insomnia where benzodiazepines and zopiclone are contraindicated
Prerequisites (tick boxes where appropriate)

- ○ Patient has insomnia and benzodiazepines and zopiclone are contraindicated

and

- ○ For in-hospital use only

I confirm that the above details are correct:

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