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	PATIENT:
Name:	Name:
Ward:	NHI:
Mercaptopurine	
INITIATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) Orecommended by a paediatric haematologist or paediatric oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. The patient requires a total dose of less than one full 50 mg tablet per day	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)	
Prescribed by, or recommended by a paediatric haematologist or pathogonal been endorsed by the Health NZ Hospital. The patient requires a total dose of less than one full 50 mg tablet pathogonal part of the patient requires a total dose of less than one full 50 mg tablet pathogonal part of the patient requires a total dose of less than one full 50 mg tablet pathogonal part of the patient requires a total dose of less than one full 50 mg tablet pathogonal pa	ediatric oncologist, or in accordance with a protocol or guideline that has er day