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:
Betaine	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a metabolic physician, or in accommod NZ Hospital.	ordance with a protocol or guideline that has been endorsed by the Health
The patient has a confirmed diagnosis of homocystinuria	
O A cystathionine beta-synthase (CBS) deficiency or O A 5,10-methylene-tetrahydrofolate reductase (MTHFR) or O A disorder of intracellular cobalamin metabolism	deficiency
An appropriate homocysteine level has not been achieved des	spite a sufficient trial of appropriate vitamin supplementation
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a metabolic physician, or in accommodate to NZ Hospital.  and O The treatment remains appropriate and the patient is benefiting from	ordance with a protocol or guideline that has been endorsed by the Health

I confirm that the above details are correct:

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