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: .....

Riboflavin

INITIATION
Re-assessment required after 6 months
Prerequisites (tick box where appropriate)

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

and

- ○ The patient has a suspected inborn error of metabolism that may respond to riboflavin supplementation

CONTINUATION
Re-assessment required after 24 months
Prerequisites (tick boxes where appropriate)

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

and

- ○ The patient has a confirmed diagnosis of an inborn error of metabolism that responds to riboflavin supplementation

and

- ○ The treatment remains appropriate and the patient is benefiting from treatment

HOSPITAL

I confirm that the above details are correct:

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