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: .....

Taurine

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

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

and

- ○ The patient has a suspected specific mitochondrial disorder that may respond to taurine supplementation

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

- ○ Prescribed by, or recommended by a metabolic physician, 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 a specific mitochondrial disorder which responds to taurine supplementation

and

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

I confirm that the above details are correct:

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