

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:

Tacrolimus

INITIATION – organ transplant recipients

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by any specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

For use in organ transplant recipients

INITIATION – non-transplant indications*

Prerequisites (tick boxes where appropriate)

Prescribed by, or recommended by any specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

Patient requires long-term systemic immunosuppression

and

Ciclosporin has been trialled and discontinued treatment because of unacceptable side effects or inadequate clinical response

or

Patient is a child with nephrotic syndrome*

Note: Indications marked with * are unapproved indications

I confirm that the above details are correct:

Signed: Date: