## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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

()

Re-a		smer	t required after 12 months (tick boxes where appropriate)	
and			bribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.	
	O The patient has a confirmed diagnosis of homocystinuria			
		or	O A cystathionine beta-synthase (CBS) deficiency	
		or	O A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency	
			O A disorder of intracellular cobalamin metabolism	
	and	0	An appropriate homocysteine level has not been achieved despite 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 accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

The treatment remains appropriate and the patient is benefiting from treatment

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