

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:

Riluzole

INITIATION

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

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

and

The patient has amyotrophic lateral sclerosis with disease duration of 5 years or less

and

The patient has at least 60 percent of predicted forced vital capacity within 2 months prior to the initial application

and

The patient has not undergone a tracheostomy

and

The patient has not experienced respiratory failure

and

The patient is ambulatory

or

The patient is able to use upper limbs

or

The patient is able to swallow

CONTINUATION

Re-assessment required after 18 months

Prerequisites (tick boxes where appropriate)

The patient has not undergone a tracheostomy

and

The patient has not experienced respiratory failure

and

The patient is ambulatory

or

The patient is able to use upper limbs

or

The patient is able to swallow

I confirm that the above details are correct:

Signed: Date: