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:
Melatonin	
INITIATION - insomnia secondary to neurodevelopmental disorder Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a psychiatrist, paediatrician, neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Patient has been diagnosed with persistent and distressing insomnia secondary to a neurodevelopmental disorder (including, but not limited to, autism spectrum disorder or attention deficit hyperactivity disorder) and O Behavioural and environmental approaches have been tried or are inappropriate and of Funded modified-release melatonin is to be given at doses no greater than 10 mg per day and O Patient is aged 18 years or under	
CONTINUATION – insomnia secondary to neurodevelopmental disorder Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a psychiatrist, paediatrician, neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and O Patient is aged 18 years or under	
O Patient has demonstrated clinically meaningful benefit from fur	scontinuation within the past 12 months and has had a recurrence of
INITIATION – insomnia where benzodiazepines and zopiclone are contraindicated Prerequisites (tick boxes where appropriate) O Patient has insomnia and benzodiazepines and zopiclone are contraindicated and For the second secon	
O For in-hospital use only	

Signed: Date: