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.

PRESCF	RIBER	PATIENT:			
Name: .		Name:			
Ward:		NHI:			
Betaine	e				
Prerequ	essment required after 12 months uisites (tick boxes where appropriate)	ordance with a protocol or guideline that has been endorsed by the Health			
and	The patient has a confirmed diagnosis of homocystinuria				
	O A cystathionine beta-synthase (CBS) deficiency or O A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency or O A disorder of intracellular cobalamin metabolism				
	O An appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation				
Re-asse	NUATION essment required after 12 months uisites (tick box where appropriate)				
and	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.				
O The treatment remains appropriate and the patient is benefiting from treatment					

I confirm that the above details are correct:

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