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:
Sodium phenylbutyrate	
INITIATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) 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. For the chronic management of a urea cycle disorder involving a deficiency of carbamylphosphate synthetase, ornithine transcarbamylase or argininosuccinate synthetase	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accommodate NZ Hospital. and O The treatment remains appropriate and the patient is benefiting from	ordance with a protocol or guideline that has been endorsed by the Health

I confirm that the above details are correct:		
Signed:	Date:	