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: .....

Modafinil

INITIATION – Narcolepsy

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 a diagnosis of narcolepsy and has excessive daytime sleepiness associated with narcolepsy occurring almost daily for three months or more

and

❍ The patient has a multiple sleep latency test with a mean sleep latency of less than or equal to 10 minutes and 2 or more sleep onset rapid eye movement periods

or

❍ The patient has at least one of: cataplexy, sleep paralysis or hypnagogic hallucinations

and

❍ An effective dose of a listed formulation of methylphenidate or dexamphetamine has been trialled and discontinued because of intolerable side effects

or

❍ Methylphenidate and dexamphetamine are contraindicated

I confirm that the above details are correct:

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