## 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.

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nital inherited anaemia	
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apy or deferiprone and desferrioxamine combination therapy or cardiac MRI T2*  Ing or diarrhoea  Pranulocytosis (defined as an absolute neutrophil count episodes) of moderate neutropenia (ANC 0.5 - 1.0 cells per	
CONTINUATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and	
tolerated and has resulted in clinical improvement in all three els  Ited in clinical stability or continued improvement in all three els.	
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I confirm that the above details are correct:	
Signed:	Date: