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) Prescribed by, or recommended by a psychiatrist, paediatrician, neuroguideline that has been endorsed by the Health NZ Hospital. Patient has been diagnosed with persistent and distressing insolimited to, autism spectrum disorder or attention deficit hyperaction and Behavioural and environmental approaches have been tried or and Funded modified-release melatonin is to be given at doses no and Patient is aged 18 years or under	somnia secondary to a neurodevelopmental disorder (including, but not ctivity disorder)
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. O Patient is aged 18 years or under and O Patient has demonstrated clinically meaningful benefit from funded modified-release melatonin (clinician determined) and O Patient has had a trial of funded modified-release melatonin discontinuation within the past 12 months and has had a recurrence of persistent and distressing insomnia Funded modified-release melatonin is to be given at doses no greater than 10 mg per day	
INITIATION – insomnia where benzodiazepines and zopiclone are contrained Prerequisites (tick boxes where appropriate) Organical Patient has insomnia and benzodiazepines and zopiclone are and Programment of the programment	

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