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:
Mercaptopurine	
INITIATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a paediatric haematologist or pabeen endorsed by the Health NZ Hospital.  and O The patient requires a total dose of less than one full 50 mg tablet p	nediatric oncologist, or in accordance with a protocol or guideline that has er day
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a paediatric haematologist or pabeen endorsed by the Health NZ Hospital.  and O The patient requires a total dose of less than one full 50 mg tablet p	nediatric oncologist, or in accordance with a protocol or guideline that has er day

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