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: .....

Betaine

INITIATION
Re-assessment required after 12 months
Prerequisites (tick boxes 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.

and

- ○ The patient has a confirmed diagnosis of homocystinuria

and

- ○ A cystathionine beta-synthase (CBS) deficiency

or

- ○ A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency

or

- ○ A disorder of intracellular cobalamin metabolism

and

- ○ An appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation

CONTINUATION
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.

and

- ○ The treatment remains appropriate and the patient is benefiting from treatment

I confirm that the above details are correct:

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