## 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.

| PRESCRIBER  | PATIENT: |
|---|----------|
| Name:   | Name:    |
| Ward:   | NHI:     |
| Coenzyme Q10  |          |
| INITIATION<br>Re-assessment required after 6 months<br>Prerequisites (tick box where appropriate)<br>O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health<br>NZ Hospital.<br>and<br>O The patient has a suspected inborn error of metabolism that may respond to coenzyme Q10 supplementation           |          |
| CONTINUATION   Re-assessment required after 24 months   Prerequisites (tick boxes where appropriate)   O 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 O   The patient has a confirmed diagnosis of an inborn error of metabolism that responds to coenzyme Q10 supplementation |          |

O The treatment remains appropriate and the patient is benefiting from treatment

I confirm that the above details are correct: