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: .....

## Taurine

**INITIATION**
Re-assessment required after 6 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 patient has a suspected specific mitochondrial disorder that may respond to taurine supplementation

**CONTINUATION**
Re-assessment required after 24 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 a specific mitochondrial disorder which responds to taurine supplementation

**and**

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



I confirm that the above details are correct:

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