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.

PRESCRIB	ER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Febuxos	tat		
INITIATIOI Prerequis		Gout (tick boxes where appropriate)	
and	O	Patient has been diagnosed with gout	
INITIATIOI Re-assess Prerequis	rescileatif	The patient has experienced intolerable side effects from allopurinol surate remains greater than 0.36 mmol/l despite use of probenecid at The patient has renal impairment such that probenecid is contraindic greater than 0.36 mmol/l despite optimal treatment with allopurinol (s	tolerated dose such that treatment discontinuation is required and serum doses of up to 2 g per day or maximum tolerated dose ated or likely to be ineffective and serum urate remains see Note)  r benzbromarone for treatment of gout.
Re-assess Prerequis	ment ites ( Presci Health	ON – Tumour lysis syndrome nt required after 6 weeks s (tick box where appropriate) cribed by, or recommended by a haematologist or oncologist, or in accordant NZ Hospital. treatment remains appropriate and patient is benefitting from treatment	ce with a protocol or guideline that has been endorsed by the

I confirm that the above details are correct:

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