## 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.

PRES	CRIB	ER	PATIENT:				
Name	:						
Ward							
Riluzole							
Re-a	NITIATION le-assessment required after 6 months rerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endor by the Health NZ Hospital.						
	and and and and and or or	The patient has amyotrophic lateral sclerosis with disease duration of 5 years or less The patient has at least 60 percent of predicted forced vital capacity within 2 months prior to the initial application The patient has not undergone a tracheostomy The patient has not experienced respiratory failure O The patient is ambulatory O The patient is able to use upper limbs O The patient is able to swallow					

## CONTINUATION

Re-assessment required after 18 months

Prerequisites (tick boxes where appropriate)

	( and	O The patient has not experienced respiratory failure				
	and ( and					
		or or	0	The patient is ambulatory		
			Ο	The patient is able to use upper limbs		
			Ο	The patient is able to swallow		

I confirm that the above details are correct: