

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: