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.

	PATIENT:
Name:	Name:
Vard:	NHI:
isdexamfetamine dimesilate	
INITIATION Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by a paediatri Health NZ Hospital.	ician or psychiatrist, or in accordance with a protocol or guideline that has been endorsed by the
ADHD (Attention Deficit and Hype and Diagnosed according to DSM-V or and Patient is taking a currently and has not received sufficient or Patient is taking a currently effective due to significant a or There is significant concern or Patient is taking a currently release) which has not been or There is significant concern or Patient would have been but has been unable to and	

Signed: Date: