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	PATIENT:
Name:	Name:
Ward:	NHI:
Riluzole	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a neurologist or respiratory specified by the Health NZ Hospital.	cialist, or in accordance with a protocol or guideline that has been endorsed
The patient has amyotrophic lateral sclerosis with disease durand The patient has at least 60 percent of predicted forced vital call and The patient has not undergone a tracheostomy and The patient has not experienced respiratory failure and The patient is ambulatory The patient is able to use upper limbs The patient is able to swallow	
CONTINUATION Re-assessment required after 18 months Prerequisites (tick boxes where appropriate) The patient has not undergone a tracheostomy and The patient has not experienced respiratory failure and The patient is ambulatory or The patient is able to use upper limbs or The patient is able to swallow	

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