## 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.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Melatonin	
guideline that has been endorsed by the Health NZ Hospital.	ed or are inappropriate
Re-assessment required after 12 months  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a psychiatrist, paediatrician, guideline that has been endorsed by the Health NZ Hospital.  and	neurologist or respiratory specialist, or in accordance with a protocol or
Patient is aged 18 years or under and Patient has demonstrated clinically meaningful benefit from and	in discontinuation within the past 12 months and has had a recurrence of
INITIATION – insomnia where benzodiazepines and zopiclone are con Prerequisites (tick boxes where appropriate)	ntraindicated
Patient has insomnia and benzodiazepines and zopiclone and For in-hospital use only	are contraindicated

I confirm that the above details are correct:	
Signed:	Date: