## 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.

		ominantly familing, see the openia Authority Official.		
PRESCRI	IBER	PATIENT:	PATIENT:	
Name:		Name:	Name:	
Ward:		NHI:		
Febuxo	stat			
INITIATIO Prerequi		Gout (tick boxes where appropriate)		
and	O	Patient has been diagnosed with gout		
	0.4	O The patient has a serum urate level greater than 0.36 mmol/l despite treatment with allopurinol at doses of at le and addition of probenecid at doses of up to 2 g per day or maximum tolerated dose	ast 600 mg/day	
	or	The patient has experienced intolerable side effects from allopurinol such that treatment discontinuation is required and serum urate remains greater than 0.36 mmol/l despite use of probenecid at doses of up to 2 g per day or maximum tolerated dose		
	or	O The patient has renal impairment such that probenecid is contraindicated or likely to be ineffective and serum urate remains greater than 0.36 mmol/l despite optimal treatment with allopurinol (see Note)		
	<u> </u>	O The patient has previously had an initial Special Authority approval for benzbromarone for treatment of gout.		
Re-assessment required after 6 weeks  Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by Health NZ Hospital.  and  O Patient is scheduled to receive cancer therapy carrying an intermediate or high risk of tumour lysis syndrome				
and	O	Patient has a documented history of allopurinol intolerance		
Re-asses	ssmer i <b>sites</b>	DN - Tumour lysis syndrome nt required after 6 weeks (tick box where appropriate) cribed by, or recommended by a haematologist or oncologist, or in accordance with a protocol or guideline that has been	an andorsed by the	
and	Healt	treatment remains appropriate and patient is benefitting from treatment	en endorsed by the	

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