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

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Defibrotide

INITIATION

Prerequisites (tick box where appropriate)

- ○ Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ Patient has moderate or severe sinusoidal obstruction syndrome as a result of chemotherapy or regimen-related toxicities

I confirm that the above details are correct:

Signed: ..... Date: .....