HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:
Tacrolimus	
INITIATION – organ transplant recipients Prerequisites (tick boxes where appropriate) Or For use in organ transplant recipients or Or The individual is receiving induction therapy for an organ trans	plant
INITIATION – non-transplant indications* Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by any specialist, or in accordance thospital. and	with a protocol or guideline that has been endorsed by the Health NZ
Patient requires long-term systemic immunosuppression O Ciclosporin has been trialled and discontinued treatment or O Patient is a child with nephrotic syndrome*	t because of unacceptable side effects or inadequate clinical response
Note: Indications marked with * are unapproved indications	

I confirm that the above details are correct:

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