# 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: .....

## Riluzole

**INITIATION**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

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

**and**

- ○ The patient has amyotrophic lateral sclerosis with disease duration of 5 years or less

**and**

- ○ The patient has at least 60 percent of predicted forced vital capacity within 2 months prior to the initial application

**and**

- ○ 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

**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



I confirm that the above details are correct:

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