

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: .....

**Taurine**

**INITIATION**

Re-assessment required after 6 months

**Prerequisites** (tick box where appropriate)

☐ Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

☐ The patient has a suspected specific mitochondrial disorder that may respond to taurine supplementation

**CONTINUATION**

Re-assessment required after 24 months

**Prerequisites** (tick boxes where appropriate)

☐ Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

☐ The patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation

and

☐ The treatment remains appropriate and the patient is benefiting from treatment

I confirm that the above details are correct:

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