

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: Name:

Ward: NHI:

Melatonin

INITIATION – insomnia secondary to neurodevelopmental disorder

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

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

and

Patient has been diagnosed with persistent and distressing insomnia secondary to a neurodevelopmental disorder (including, but not limited to, autism spectrum disorder or attention deficit hyperactivity disorder)

and

Behavioural and environmental approaches have been tried or are inappropriate

and

Funded modified-release melatonin is to be given at doses no greater than 10 mg per day

and

Patient is aged 18 years or under

CONTINUATION – insomnia secondary to neurodevelopmental disorder

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

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

and

Patient is aged 18 years or under

and

Patient has demonstrated clinically meaningful benefit from funded modified-release melatonin (clinician determined)

and

Patient has had a trial of funded modified-release melatonin discontinuation within the past 12 months and has had a recurrence of persistent and distressing insomnia

and

Funded modified-release melatonin is to be given at doses no greater than 10 mg per day

INITIATION – insomnia where benzodiazepines and zopiclone are contraindicated

Prerequisites (tick boxes where appropriate)

Patient has insomnia and benzodiazepines and zopiclone are contraindicated

and

For in-hospital use only

I confirm that the above details are correct:

Signed: Date: