

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:

Sodium phenylbutyrate

INITIATION

Re-assessment required after 12 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

For the chronic management of a urea cycle disorder involving a deficiency of carbamylphosphate synthetase, ornithine transcarbamylase or argininosuccinate synthetase

CONTINUATION

Re-assessment required after 12 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 treatment remains appropriate and the patient is benefiting from treatment

I confirm that the above details are correct:

Signed: Date: