Form RS1834
April 2026

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: ....

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

HOSPITAL

I confirm that the above details are correct:

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