

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: .....

**Tacrolimus**

**INITIATION – organ transplant recipients**

**Prerequisites** (tick boxes where appropriate)

- For use in organ transplant recipients  
**or**  
 The individual is receiving induction therapy for an organ transplant

**INITIATION – non-transplant indications\***

**Prerequisites** (tick boxes where appropriate)

- Prescribed by, or recommended by any specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  
**and**  
 Patient requires long-term systemic immunosuppression  
**and**  
 Ciclosporin has been trialled and discontinued treatment because of unacceptable side effects or inadequate clinical response  
**or**  
 Patient is a child with nephrotic syndrome\*

Note: Indications marked with \* are unapproved indications

I confirm that the above details are correct:

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