

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: .....

**Betaine**

**INITIATION**

Re-assessment required after 12 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 homocystinuria

and

- A cystathionine beta-synthase (CBS) deficiency  
or  
 A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency  
or  
 A disorder of intracellular cobalamin metabolism

and

- An appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation

**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: .....