

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:

Coenzyme Q10

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 inborn error of metabolism that may respond to coenzyme Q10 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 an inborn error of metabolism that responds to coenzyme Q10 supplementation

and

The treatment remains appropriate and the patient is benefiting from treatment

I confirm that the above details are correct:

Signed: Date: