

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: .....

**Baricitinib**

**INITIATION – moderate to severe COVID-19\***

Re-assessment required after 14 days

**Prerequisites** (tick boxes where appropriate)

- Patient has confirmed (or probable) COVID-19\*
- and  Oxygen saturation of < 92% on room air, or requiring supplemental oxygen
- and  Patient is receiving adjunct systemic corticosteroids, or systemic corticosteroids are contraindicated
- and  Baricitinib is to be administered at doses no greater than 4 mg daily for up to 14 days
- and  Baricitinib is not to be administered in combination with tocilizumab

Note: Indications marked with \* are unapproved indications.

I confirm that the above details are correct:

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