

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:

Hydroxychloroquine

INITIATION

Prerequisites (tick boxes where appropriate)

- Rheumatoid arthritis
- or Systemic or discoid lupus erythematosus
- or Malaria treatment or suppression
- or Relevant dermatological conditions (cutaneous forms of lupus and lichen planus, cutaneous vasculitides and mucosal ulceration)
- or Sarcoidosis (pulmonary and non-pulmonary)

I confirm that the above details are correct:

Signed: Date: