

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**

**PATIENT:**

Name: .....

Name: .....

Ward: .....

NHI: .....

**Ezetimibe**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- Patient has a calculated absolute risk of cardiovascular disease of at least 15% over 5 years
- and
- Patient's LDL cholesterol is 2.0 mmol/litre or greater
- and
- The patient has rhabdomyolysis (defined as muscle aches and creatine kinase more than 10 × normal) when treated with one statin
- or
- The patient is intolerant to both simvastatin and atorvastatin
- or
- The patient has not reduced their LDL cholesterol to less than 2.0 mmol/litre with the use of the maximal tolerated dose of atorvastatin

I confirm that the above details are correct:

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