

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: .....

**Alpha tocopheryl**

**INITIATION – Cystic fibrosis**

**Prerequisites** (tick boxes where appropriate)

Cystic fibrosis patient

and

Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck)

or

The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for the patient

**INITIATION – Osteoradionecrosis**

**Prerequisites** (tick box where appropriate)

For the treatment of osteoradionecrosis

**INITIATION – Other indications**

**Prerequisites** (tick boxes where appropriate)

Infant or child with liver disease or short gut syndrome

and

Requires vitamin supplementation

and

Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck)

or

The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for patient

I confirm that the above details are correct:

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