HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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: .....

Iloprost - Nebuliser soln 10 mcg per ml, 2 ml

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ For use in patients with a valid Special Authority approval for iloprost by the Pulmonary Arterial Hypertension Panel

or

- ○ For diagnostic use in catheter laboratories

or

- ○ For use following mitral or tricuspid valve surgery

or

- ○ In-hospital stabilisation in emergency situations

I confirm that the above details are correct:

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