

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: .....

**Clarithromycin**

**INITIATION – Tab 250 mg and oral liquid**

**Prerequisites** (tick boxes where appropriate)

- Atypical mycobacterial infection
- or
- Mycobacterium tuberculosis infection where there is drug resistance or intolerance to standard pharmaceutical agents
- or
- Helicobacter pylori eradication
- or
- Prophylaxis of infective endocarditis associated with surgical or dental procedures if amoxicillin is contra-indicated

**INITIATION – Tab 500 mg**

**Prerequisites** (tick box where appropriate)

- Helicobacter pylori eradication

**INITIATION – Infusion**

**Prerequisites** (tick boxes where appropriate)

- Atypical mycobacterial infection
- or
- Mycobacterium tuberculosis infection where there is drug resistance or intolerance to standard pharmaceutical agents
- or
- Community-acquired pneumonia

I confirm that the above details are correct:

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