

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: .....

**Aprotinin**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by a cardiac anaesthetist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

Paediatric patient undergoing cardiopulmonary bypass procedure

or  
 Adult patient undergoing cardiac surgical procedure where the significant risk of massive bleeding outweighs the potential adverse effects of the drug

I confirm that the above details are correct:

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