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: .....

Clofazimine

INITIATION

Prerequisites (tick box where appropriate)

- ○ Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Te Whatu Ora Hospital.

I confirm that the above details are correct:

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