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: .....

Carbohydrate

INITIATION – Use as an additive
Prerequisites (tick boxes where appropriate)

- ◯ Cystic fibrosis
- **or** ◯ Chronic kidney disease
- **or** ◯ Cancer in children
- **or** ◯ Cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years
- **or** ◯ Faltering growth in an infant/child
- **or** ◯ Bronchopulmonary dysplasia
- **or** ◯ Premature and post premature infant
- **or** ◯ Inborn errors of metabolism

INITIATION – Use as a module
Prerequisites (tick box where appropriate)

◯ For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

I confirm that the above details are correct:

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