Form	<b>RS1518</b>
April 20	24

## 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	PATIENT:
Name:	Name:
Ward:	NHI:

## Long-acting muscarinic antagonists with long-acting beta-adrenoceptor agonists

INITIATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)	
<ul> <li>Patient has been stabilised on a long acting muscarinic antagonist</li> <li>and</li> <li>The prescriber considers that the patient would receive additional benefit from switching to a combination product</li> </ul>	
CONTINUATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)	
<pre>O Patient is compliant with the medication and O Patient has experienced improved COPD symptom control (prescriber determined)</pre>	

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