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: .....

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: .....