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: .....

## Enteral liquid peptide formula

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- ○ Patient has impaired gastrointestinal function and either cannot tolerate polymeric feeds, or polymeric feeds are unsuitable

**and**

- ○ Severe malabsorption
- **or** ○ Short bowel syndrome
- **or** ○ Intractable diarrhoea
- **or** ○ Biliary atresia
- **or** ○ Cholestatic liver diseases causing malabsorption
- **or** ○ Cystic fibrosis
- **or** ○ Proven fat malabsorption
- **or** ○ Severe intestinal motility disorders causing significant malabsorption
- **or** ○ Intestinal failure
- **or**
  - ○ The patient is currently receiving funded amino acid formula
  - **and** ○ The patient is to be trialled on, or transitioned to, an enteral liquid peptide formula

**and**

- ○ A semi-elemental or partially hydrolysed powdered feed has been reasonably trialled and considered unsuitable
- **or** ○ For step down from intravenous nutrition

Note: A reasonable trial is defined as a 2-4 week trial.

**CONTINUATION**

**Prerequisites** (tick boxes where appropriate)

- ○ An assessment as to whether the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed formula has been undertaken

**and**

- ○ The outcome of the assessment is that the patient continues to require an enteral liquid peptide formula



I confirm that the above details are correct:

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