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: .....

Baricitinib

INITIATION – moderate to severe COVID-19*
Re-assessment required after 14 days
Prerequisites (tick boxes where appropriate)

- ○ Patient has confirmed (or probable) COVID-19*

and

- ○ Oxygen saturation of < 92% on room air, or requiring supplemental oxygen

and

- ○ Patient is receiving adjunct systemic corticosteroids, or systemic corticosteroids are contraindicated

and

- ○ Baricitinib is to be administered at doses no greater than 4 mg daily for up to 14 days

and

- ○ Baricitinib is not to be administered in combination with tocilizumab

Note: Indications marked with * are unapproved indications.

I confirm that the above details are correct:

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