Form RS1470 July 2024

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:
Fat-modified feed				
INITIATION Prerequisites (tick boxes where appropriate)				
	or	O	Patient has metabolic disorders of fat metabolism	
		0	Patient has a chyle leak	
	or O		Modified as a modular feed, made from at least one nutrient m Pharmaceutical Schedule, for adults	odule and at least one further product listed in Section D of the

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