

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:

Multivitamin renal

INITIATION

Prerequisites (tick boxes where appropriate)

- or**
- The patient has chronic kidney disease and is receiving either peritoneal dialysis or haemodialysis
 - The patient has chronic kidney disease grade 5, defined as patient with an estimated glomerular filtration rate of < 15 ml/min/1.73m² body surface area (BSA)

I confirm that the above details are correct:

Signed: Date: