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: .....

Hydroxychloroquine

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ Rheumatoid arthritis

or

- ○ Systemic or discoid lupus erythematosus

or

- ○ Malaria treatment or suppression

or

- ○ Relevant dermatological conditions (cutaneous forms of lupus and lichen planus, cutaneous vasculitides and mucosal ulceration)

or

- ○ Sarcoidosis (pulmonary and non-pulmonary)

I confirm that the above details are correct:

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