# 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: .....

## Ursodeoxycholic acid

**INITIATION – Alagille syndrome or progressive familial intrahepatic cholestasis**
**Prerequisites** (tick boxes where appropriate)

- ○ Patient has been diagnosed with Alagille syndrome

**or**

- ○ Patient has progressive familial intrahepatic cholestasis

**INITIATION – Chronic severe drug induced cholestatic liver injury**
**Prerequisites** (tick boxes where appropriate)

- ○ Patient has chronic severe drug induced cholestatic liver injury

**and**

- ○ Cholestatic liver injury not due to Total Parenteral Nutrition (TPN) use in adults

**and**

- ○ Treatment with ursodeoxycholic acid may prevent hospital admission or reduce duration of stay

**INITIATION – Primary biliary cholangitis**
**Prerequisites** (tick boxes where appropriate)

- ○ Primary biliary cholangitis confirmed by antimitochondrial antibody titre (AMA) > 1:80, and raised cholestatic liver enzymes with or without raised serum IgM or, if AMA is negative by liver biopsy

**and**

- ○ Patient not requiring a liver transplant (bilirubin > 100 umol/l; decompensated cirrhosis

**INITIATION – Pregnancy**
**Prerequisites** (tick box where appropriate)

- ○ Patient diagnosed with cholestasis of pregnancy

**INITIATION – Haematological transplant**
**Prerequisites** (tick boxes where appropriate)

- ○ Patient at risk of veno-occlusive disease or has hepatic impairment and is undergoing conditioning treatment prior to allogenic stem cell or bone marrow transplantation

**and**

- ○ Treatment for up to 13 weeks

**INITIATION – Total parenteral nutrition induced cholestasis**
**Prerequisites** (tick boxes where appropriate)

- ○ Paediatric patient has developed abnormal liver function as indicated on testing which is likely to be induced by TPN

**and**

- ○ Liver function has not improved with modifying the TPN composition



I confirm that the above details are correct:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Ursodeoxycholic acid *- continued*

**INITIATION – prevention of sinusoidal obstruction syndrome**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

❍ The patient is enrolled in the Children's Oncology Group AALL1732 trial

**and**

❍ The patient has leukaemia/lymphoma and is receiving inotuzumab ozogamicin



I confirm that the above details are correct:

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