

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:

Finasteride

INITIATION

Prerequisites (tick boxes where appropriate)

Patient has symptomatic benign prostatic hyperplasia

and

The patient is intolerant of non-selective alpha blockers or these are contraindicated

or

Symptoms are not adequately controlled with non-selective alpha blockers



I confirm that the above details are correct:

Signed: Date: