

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: .....

**Ivabradine**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

Patient is indicated for computed tomography coronary angiography

and

Patient has a heart rate of greater than 70 beats per minute while taking a maximally tolerated dose of beta blocker

or

Patient is unable to tolerate beta blockers

I confirm that the above details are correct:

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