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.

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orotocol or guideline that has been endorsed by the Health S or an IPSS-R score of less than 3.5) associated with
protocol or guideline that has been endorsed by the Health

I confirm that the above details are correct:

Signed: Date: