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: .....

Levosimendan

INITIATION – Heart transplant

Prerequisites (tick boxes where appropriate)

- ○ For use as a bridge to heart transplant, in patients who have been accepted for transplant

or

- ○ For the treatment of heart failure following heart transplant

INITIATION – Heart failure

Prerequisites (tick box where appropriate)

- ○ Prescribed by, or recommended by a cardiologist or intensivist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ For the treatment of severe acute decompensated heart failure that is non-responsive to dobutamine

I confirm that the above details are correct:

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