## 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	PATIENT:
Name:	Name:
Ward:	NHI:

## **Diabetic Products**

INITIATION Prerequisites (tick boxes where appropriate)			
		0	For patients with type I or type II diabetes suffering weight loss and malnutrition that requires nutritional support
	or	Ο	For patients with pancreatic insufficiency
	or	Ο	For patients who have, or are expected to, eat little or nothing for 5 days
	or	Ο	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
	or	Ο	For use pre- and post-surgery
	or	Ο	For patients being tube-fed
	or	Ο	For tube-feeding as a transition from intravenous nutrition

I confirm that the above details are correct: