

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: .....

**Preterm formula**

**INITIATION**

**Prerequisites** (tick box where appropriate)

- For infants born before 33 weeks' gestation or weighing less than 1.5 kg at birth

HOSPITAL

I confirm that the above details are correct:

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