

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:

Carbohydrate

INITIATION – Use as an additive

Prerequisites (tick boxes where appropriate)

- Cystic fibrosis
- or Chronic kidney disease
- or Cancer in children
- or Cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years
- or Faltering growth in an infant/child
- or Bronchopulmonary dysplasia
- or Premature and post premature infant
- or Inborn errors of metabolism

INITIATION – Use as a module

Prerequisites (tick box where appropriate)

- For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

I confirm that the above details are correct:

Signed: Date: