HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 1

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:
Long-acting muscarinic antagonists with long-acting beta-adrenoceptor agonists		
INITIATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)		
•	Patient has been stabilised on a long acting muscarinic antagonist The prescriber considers that the patient would receive additional benefit from switching to a combination product	
CONTINUATION Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)		
	O Patient is compliant with the medication	
	O Patient has experienced improved COPD symptom control (pr	rescriber determined)