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: ....

Aprotinin

INITIATION

Prerequisites (tick boxes where appropriate)

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

and

○ Paediatric patient undergoing cardiopulmonary bypass procedure

or

○ Adult patient undergoing cardiac surgical procedure where the significant risk of massive bleeding outweighs the potential adverse effects of the drug

I confirm that the above details are correct:

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