

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: .....

**Fat**

**INITIATION – Use as an additive**

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has inborn errors of metabolism
- or ☐ Faltering growth in an infant/child
- or ☐ Bronchopulmonary dysplasia
- or ☐ Fat malabsorption
- or ☐ Lymphangiectasia
- or ☐ Short bowel syndrome
- or ☐ Infants with necrotising enterocolitis
- or ☐ Biliary atresia
- or ☐ For use in a ketogenic diet
- or ☐ Chyle leak
- or ☐ Ascites
- or ☐ Patient has increased energy requirements, and for whom dietary measures have not been successful

**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: .....