

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: .....

**Extensively hydrolysed formula**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

☐ Cows' milk formula is inappropriate due to severe intolerance or allergy to its protein content

and

☐ Soy milk formula has been reasonably trialed without resolution of symptoms

or

☐ Soy milk formula is considered clinically inappropriate or contraindicated

or

☐ Severe malabsorption

or

☐ Short bowel syndrome

or

☐ Intractable diarrhoea

or

☐ Biliary atresia

or

☐ Cholestatic liver diseases causing malabsorption

or

☐ Cystic fibrosis

or

☐ Proven fat malabsorption

or

☐ Severe intestinal motility disorders causing significant malabsorption

or

☐ Intestinal failure

or

☐ For step down from Amino Acid Formula

Note: A reasonable trial is defined as a 2-4 week trial, or signs of an immediate IgE mediated allergic reaction.

**CONTINUATION**

**Prerequisites** (tick boxes where appropriate)

☐ An assessment as to whether the infant can be transitioned to a cows' milk protein or soy infant formula has been undertaken

and

☐ The outcome of the assessment is that the infant continues to require an extensively hydrolysed infant formula

I confirm that the above details are correct:

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