

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: .....

**Non-Nucleoside Reverse Transcriptase Inhibitors**

**INITIATION – Confirmed HIV**

**Prerequisites** (tick box where appropriate)

- ☐ Patient has confirmed HIV infection

**INITIATION – Prevention of maternal transmission**

**Prerequisites** (tick boxes where appropriate)

- ☐ Prevention of maternal foetal transmission  
or  
☐ Treatment of the newborn for up to eight weeks

**INITIATION – Post-exposure prophylaxis following exposure to HIV**

**Prerequisites** (tick boxes where appropriate)

- ☐ Treatment course to be initiated within 72 hours post exposure  
and  
☐ Patient has had condomless anal intercourse or receptive vaginal intercourse with a known HIV positive person with an unknown or detectable viral load greater than 200 copies per ml  
or  
☐ Patient has shared intravenous injecting equipment with a known HIV positive person  
or  
☐ Patient has had non-consensual intercourse and the clinician considers that the risk assessment indicates prophylaxis is required  
or  
☐ Patient has had condomless anal intercourse with a person from a high HIV prevalence country or risk group whose HIV status is unknown

Note: Refer to local health pathways or the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines for PEP (<https://www.ashm.org.au>)

**INITIATION – Percutaneous exposure**

**Prerequisites** (tick box where appropriate)

- ☐ Patient has percutaneous exposure to blood known to be HIV positive

I confirm that the above details are correct:

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