

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: