

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: