# HOSPITAL MEDICINES LIST
# RESTRICTIONS CHECKLIST



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: .....

## Long-acting muscarinic antagonists with long-acting beta-adrenoceptor agonists

**INITIATION**
Re-assessment required after 2 years
**Prerequisites** (tick boxes where appropriate)

- ○ Patient has been stabilised on a long acting muscarinic antagonist

**and**

- ○ The prescriber considers that the patient would receive additional benefit from switching to a combination product

**CONTINUATION**
Re-assessment required after 2 years
**Prerequisites** (tick boxes where appropriate)

- ○ Patient is compliant with the medication

**and**

- ○ Patient has experienced improved COPD symptom control (prescriber determined)



I confirm that the above details are correct:

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