

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:

Ivabradine

INITIATION

Prerequisites (tick boxes where appropriate)

- ☐ Patient is indicated for computed tomography coronary angiography
- and
- ☐ Patient has a heart rate of greater than 70 beats per minute while taking a maximally tolerated dose of beta blocker
- or
- ☐ Patient is unable to tolerate beta blockers

I confirm that the above details are correct:

Signed: Date: