

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:

Alpha tocopheryl

INITIATION – Cystic fibrosis

Prerequisites (tick boxes where appropriate)

☐ Cystic fibrosis patient
and

- or
- ☐ Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck)
- ☐ The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for the patient

INITIATION – Osteoradionecrosis

Prerequisites (tick box where appropriate)

☐ For the treatment of osteoradionecrosis

INITIATION – Other indications

Prerequisites (tick boxes where appropriate)

☐ Infant or child with liver disease or short gut syndrome
and
☐ Requires vitamin supplementation
and

- or
- ☐ Patient has tried and failed the other available funded fat soluble vitamin A,D,E,K supplements (Vitabdeck)
- ☐ The other available funded fat soluble vitamin A,D,E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for patient

I confirm that the above details are correct:

Signed: Date: