

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:

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INITIATION

Prerequisites (tick box where appropriate)

- ☐ For patients with haemophilia B receiving prophylaxis treatment. Access to funded treatment is managed by the Haemophilia Treathers Group in conjunction with the National Haemophilia Management Group

I confirm that the above details are correct:

Signed: Date: