

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: .....

**Nicardipine hydrochloride**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by an anaesthetist, intensivist, cardiologist or paediatric cardiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Patient has hypertension requiring urgent treatment with an intravenous agent
- or
- ☐ Patient has excessive ventricular afterload
- or
- ☐ Patient is awaiting or undergoing cardiac surgery using cardiopulmonary bypass

I confirm that the above details are correct:

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