## 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	PATIENT:
Name:	Name:
Ward:	NHI:
Protease Inhibitors	
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate)  Patient has confirmed HIV infection	
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)	
O Prevention of maternal foetal transmission or O Treatment of the newborn for up to eight weeks	
INITIATION – Post-exposure prophylaxis following exposure to HIV  Prerequisites (tick boxes where appropriate)  Or Treatment course to be initiated within 72 hours post exposure and	
Patient has had condomless anal intercourse or recept unknown or detectable viral load greater than 200 copi   Patient has shared intravenous injecting equipment wit   Patient has had non-consensual intercourse and the clared or	
Note: Refer to local health pathways or the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashn	
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate)	
O Patient has percutaneous exposure to blood known to be HIV positive	

I confirm that the above details are correct:

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