

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:

Bedaquiline

INITIATION – multi-drug resistant tuberculosis

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- ☐ The person has multi-drug resistant tuberculosis (MDR-TB)
and ☐ Ministry of Health's Tuberculosis Clinical Network has reviewed the individual case and recommends bedaquiline as part of the treatment regimen

I confirm that the above details are correct:

Signed: Date: