

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: .....

**Levosimendan**

**INITIATION – Heart transplant**

**Prerequisites** (tick boxes where appropriate)

- ☐ For use as a bridge to heart transplant, in patients who have been accepted for transplant
- or
- ☐ For the treatment of heart failure following heart transplant

**INITIATION – Heart failure**

**Prerequisites** (tick box where appropriate)

- ☐ Prescribed by, or recommended by a cardiologist or intensivist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
- and
- ☐ For the treatment of severe acute decompensated heart failure that is non-responsive to dobutamine

I confirm that the above details are correct:

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