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: .....

Betamethasone valerate with clioquinol

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ For the treatment of intertrigo

or

- ○ For continuation use

I confirm that the above details are correct:

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